ENGLISH HEALTH CARE: NOT YOUR CUP OF TEA (PART 3) — PAGE 12

Oregon Community Adopts Simple Care Page 7

Health Care News

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States Declare War on Prescription Drugs

States attempt to shift costs by mandating supplemental drug rebates

BY JOSEPH L. BAST AND MERRILL MATTHEWS

State elected officials across the country, hard-pressed to keep expensive promises they made during the good economic times of the 1990s, are considering legislation that would force drug manufacturers to pay "supplemental rebates" to have their drugs included in state Medicaid programs.

Experts warn these programs are likely to increase health care costs for the privately insured and uninsured and restrict choices for doctors and their patients. In the long term, supplemental rebates impose a blanket of complex rules and regulations on doctors and the pharmaceutical industry and create opportunities for corruption. There appear to be better ways to solve the problem of high drug prices.

Medicaid Rebates

Under current federal Medicaid law, manufacturers of brand-name drugs must pay states a rebate equal to 15.1 percent of the Average Manufacturer's Price (AMP) or the difference between the AMP and the best price the company charges its commercial customers, whichever is greater (usually 15.1 percent is the minimum rebate).

While some states use the rebate money to fund their Medicaid programs, no federal law requires them to do so. The money often goes into the general fund and can be used for virtually any purpose.

Three states—California, Florida, and New Mexico—are now telling drug manufacturers that if they want their products on the Medicaid formulary (a list of approved drugs for Medicaid recipients), they must pay a "supplemental rebate" on top of the one they already pay. Those drug companies that are unwilling or unable to hand over some extra cash will find most or all of their drugs left off of the state's formulary.

Florida adopted the supplemental rebate program in 2001, imposing an additional 10 percent rebate requirement. The law is now being litigated in the U.S. Court of Appeals for the Eleventh Judicial Circuit. According to the Center for Policy Alternatives, a liberal advocacy group promoting model legislation it calls the "Fair Market Drug Pricing Act," bills that would mandate supplemental rebates are pending in one or both houses of 24 state legislatures. (See "Supplemental Rebate Bills Pending," page 8.) New Mexico Governor Gary E. Johnson (R) signed legislation on March 6, 2002.

PRESCRIPTION continued on page 8

California Governor Gray Davis (L) chats with Florida Governor Jeb Bush (R) and Connecticut Governor John Rowland (C) prior to a National Governors Association meeting. California and Florida are now telling drug manufacturers they must pay a mandatory fee if they want their products on the Medicaid formulary. Photo: Mike Theiler / Reuters

U.S. Faces Malpractice Crisis

BY DRS. MICHAEL ARNOLD GLUECK AND ROBERT J. CIHAK

Today, American medicine is at the point of no return in its relationship with the predatory medical malpractice lawsuit industry, and with the dangerously high insurance premiums it spawns. Unless something changes—and soon—the burden will destroy vital parts of American medicine. All of us, except the trial lawyers, will be the losers.

One headline, from the December 4, 2001 issue of *USA Today*, says it all: "Soaring Malpractice Premiums Stun Many Doctors."

Writes reporter Rita Rubin: "Some physicians are seeing their malpractice insurance premiums increasing anywhere from 8 percent to 100 percent. As a result, some are dropping procedures that put them at risk of malpractice suits, moving to areas with lower rates, or even retiring early."

Nightmare Ahead

The scenario Rubin describes has been decades in the making. None of it has, or will, help the patient. Of course some medical procedures are risky—but they just might save your life.

Imagine that you and your coronary (or your

MALPRACTICE continued on page 4

The Coming Revolution in Medicine

BY JESSE S. HIXSON

In a 1901 article summarizing medical progress in the nineteenth century, Sir William Osler wrote, "bacteriology opened unheard of possibilities for the prevention of disease." Now, as we enter the twenty-first century, the same can be said of the potential for genetics and biotechnology.

The first project to map the human genome began in 1989. In September 2000, two competing efforts published "rough drafts" of the genome. In 2001, many billions of dollars were invested in basic science, research and development, and clinical studies to exploit the exploding universe of genome and genome-related information becoming available. These investments range from development of special-purpose supercomputers to process the huge volumes of data to clinical trials of DNA-replacement techniques.

Many forecasts have been made for the potential of genetic-based biotechnology. These forecasts suggest at least some of the potential developments may have profound impacts on the supply and demand for medical care and the medical service industry in the next 25 years.

Anticipated Pace of Medical Progress

Many researchers and industry analysts have speculated about the pace at which genetic biotechnology discovery and development will bring forth useful diagnostic and therapeutic applications. An amalgam of several forecasts is outlined below:

Through 2010:

- Identification of genes responsible for many common diseases.
- Understanding of the proteomics of many

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CAPITOL HILL NEWS WATCH

Scully, Thompson Wrestle with Medicare Payments

BY CONRAD F. MEIER

Thomas Scully, administrator of the Centers for Medicare and Medicaid Services (CMS), told members of the House Energy and Commerce Subcommittee on Health the Bush administration will help Congress revise the formula used to set reimbursement rates for physicians who treat Medicare beneficiaries.

Scully warned lawmakers any reimbursement increases will have to be balanced by decreased payments to other providers, keeping the overall plan budget-neutral. The Medicare program reduced physician reimbursement rates by 5.4 percent in January this year under a formula approved by Congress in 1997.

"I know it will not be easy" to find additional funds for physicians, Scully said at the hearing. But, according to Scully, the situation "is not as dire" as physician groups and many lawmakers have said. "The system is working largely as designed," Scully told CongressDaily. "Overall spending on physician care under Medicare is still rising," he added, because the volume of services provided is increasing.

Thomas Scully, top; Tommy Thompson, bottom

Scully also said the Medicare Payment Advisory Commission's (MedPAC) proposal to do away with the current Medicare provider reimbursement formula would "produce payments that are unnecessarily high," adding Congress may "want to opt for a shorter-term fix."

MedPAC criticized the reimbursement formula as "flawed" because it does not take into account increases in health care costs. The group recommended a new formula that would increase payments to physicians by 2.5 percent next year.

Provider Concerns

Also speaking at the House hearing, Ted Lewers, an American Medical Association trustee, said doctors have begun reducing the number of Medicare beneficiaries they treat in part as a result of reduced reimbursements.

Lewers said Medicare should not change reimbursements for doctors just because the economy as a whole has changed. "There is no relationship between GDP and disease. The medical needs of Medicare beneficiaries do not wane when the country falls into recession," Lewers testified.

Meanwhile, Health and Human Services (HHS) Secretary Tommy Thompson went to Capitol Hill responding to concerns about Medicare provider reimbursements at a Senate Budget Committee hearing.

He told the committee funds for a reimbursement increase were not included in President George W. Bush's fiscal year 2003 budget proposal because the administration "had to make some tough choices."

Noting Congress is expected to review Medicare payments for doctors, Thompson said, "It's important if we look at prospective payments for (physicians) that we look at prospective payments for all [health care] providers."

Lawmakers Are Concerned

The Associated Press (AP) reports lawmakers expressed concern the reduction in Medicare reimbursements to physicians will hurt seniors as physicians become reluctant to take on Medicare beneficiaries, a trend already recognized in many states.

Rep. Sherrod Brown (D-Ohio) told the AP, "We have a responsibility to the beneficiaries who depend on Medicare and to the health care professionals who make the program work to stop the 2002 cut in its tracks. It's going to be expensive but it's got to be done."

Rep. Charlie Norwood (R-Georgia), a dentist, told CongressDaily, "Providers are simply going to walk away from Medicare. They can't continue to treat patients if it costs them money."

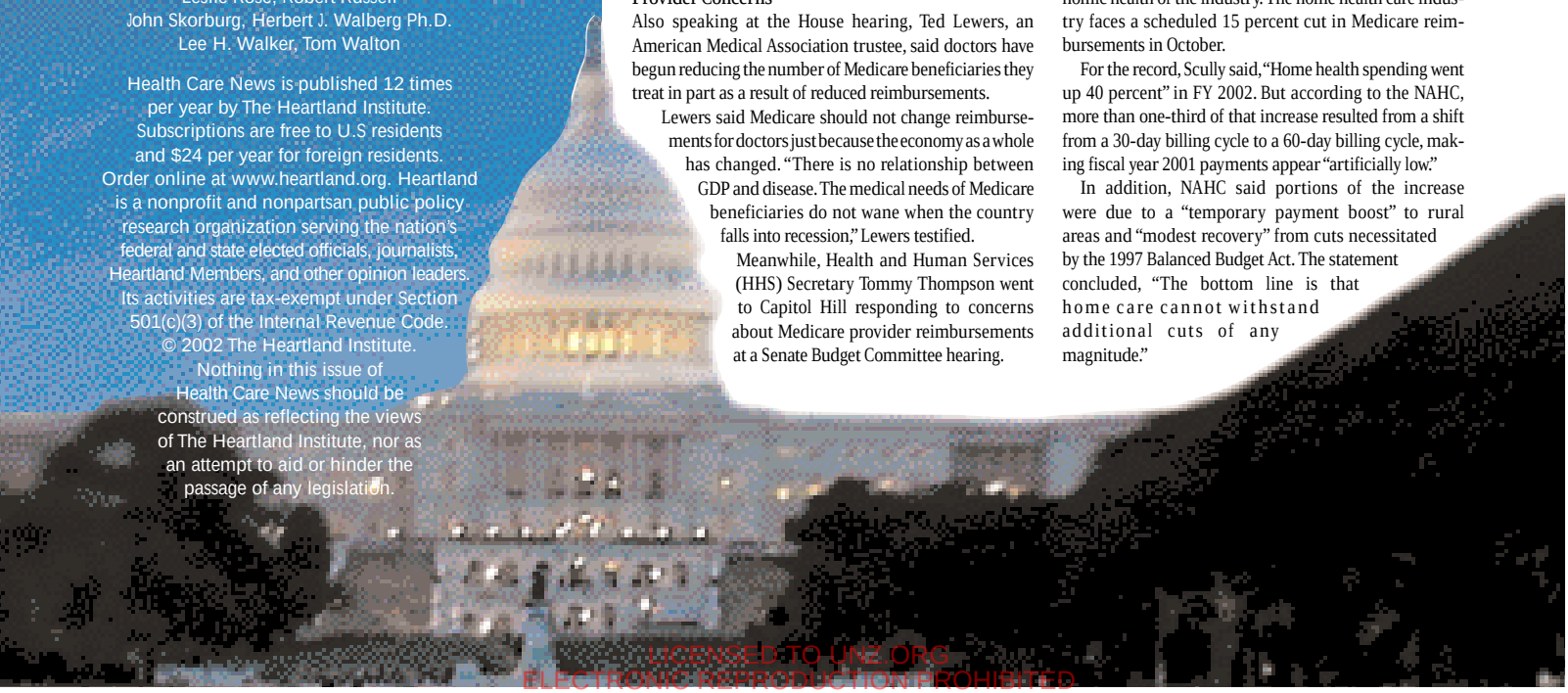
House and Senate lawmakers have proposed legislation to restore Medicare reimbursements for doctors, estimating the cost at around $1.2 billion, according to congressional officials.

Home Health Concerns

In a statement from the National Association for Home Care (NAHC), a trade group representing the home health care industry, Scully is accused of "misstating" the economic health of the industry. The home health care industry faces a scheduled 15 percent cut in Medicare reimbursements in October.

For the record, Scully said, "Home health spending went up 40 percent" in FY 2002. But according to the NAHC, more than one-third of that increase resulted from a shift from a 30-day billing cycle to a 60-day billing cycle, making fiscal year 2001 payments appear "artificially low."

In addition, NAHC said portions of the increase were due to a "temporary payment boost" to rural areas and "modest recovery" from cuts necessitated by the 1997 Balanced Budget Act. The statement concluded, "The bottom line is that home care cannot withstand additional cuts of any magnitude."



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The Pulse

BY GREG SCANDLEN

You are invited to participate in an online discussion list dealing with many of the issues we report on here. To check it out, send an e-mail to HealthBenefitsReform-subscribe@yahoogroups.com. Later on, if you want to drop off, just send an e-mail to HealthBenefitsReformunsubscribe@yahoogroups.com.

Oxymoron Reviewer Illustrates Gullibility

J.D. Kleinke's new book, *Oxymorons*, is an important book reviewed on Medscape by Medscape founder Peter Frishauf. The book is the story of one who went from a gullible embrace of managed care to total disenchantment in three short years.

Unfortunately, the review itself shows we have not yet reached the limits of gullibility. Both the book and the review of the book titter about the absurd run-up in WebMD stock, to $20 billion in valuation—ridiculous for a company with no real business plan and only a few million in sales.

But then the reviewer discusses the role of insurance brokers in our system, and says he was "astounded to learn" brokers get commissions of 3 percent to 20 percent of premiums. He decides these commissions represent "a 'shadow tax' of some $300 billion per year on premiums, more than twice what the nation spends on all prescription drugs!" Huh?!?!

With a health care system totaling about $1.5 trillion in annual spending, Frishauf actually thinks insurance brokers pocket one-fifth of that? The only way he could have arrived at that conclusion is by multiplying the total of $1.5 trillion by 20 percent—which could be justified only if all commissions were set at 20 percent and all health care spending was in the form of insurance premiums.

Frishauf acknowledges he is "not a health policy analyst or economist," but common sense should warn him insurance brokers are not making double the cost of all the prescription drugs sold in the country. The gullibility that enabled WebMD to be worth $20 billion is still alive and well on Medscape.

Source: http://www.medscape.com/viewarticle/423369

KFF Nervous about HIFA Waivers

One of the tools the Bush administration has developed to encourage innovation and experimentation in health care financing is the HIFA (Health Insurance Flexibility and Accountability) waiver for state Medicaid and SCHIP programs. Everyone in the administration insists they really want some new ideas developed in this program, and approval will be expedited.

But of course, anything short of expansion and new spending sets off alarm bells in some quarters. For instance, the Kaiser Family Foundation has released a new report on these waivers that stresses its nervousness... because the states might actually use the waiver program to *reduce* their costs.

In the same language they use for every new idea, the report's introduction says, "people with very limited incomes, including many with significant medical problems, may be left with fewer benefits and higher costs. Some people could lose their coverage and their access to needed services."

Source: http://www.kff.org/content/2002/4028/

TennCare Pays Harold Ford $1.6 Million

Just when you thought TennCare could not have been a bigger disaster, along comes a story from Memphis about how management firm MIM was able to secure lucrative prescription drug management contracts with TennCare by paying former Congressman Harold Ford $1.6 million in consulting fees over a three-year period.

At $549,000 a year, Ford's consulting contract exceeded the salary of MIM's CEO. Ford's work included lobbying HCFA, the U.S. House of Representatives, and members of the Clinton administration. Ford also received more than $1 million to work as a registered lobbyist for seven firms—including one that went bankrupt, leaving tens of millions of dollars of provider payments unpaid, according to the article.

Ford's family is very influential in Tennessee politics. One son succeeded him in the House, and another is a state senator who sits on the TennCare Oversight Committee. Ford's firm has hired the governor's former chief of staff.

Source: http://www.gomemphis.com/cr/cda/article_print/1,1250,MCA_437_1006192,00.html

Time: Health Care Issues Haven't Hit Washington Yet

In a major article in *Time* magazine, Karen Tumulty cites TennCare as one example of the trouble the health care system is in. She says it was "hailed only a few years ago as a national model for covering the working poor." But now it costs the state $6 billion a year and is likely to drop 500,000 people from the rolls.

TennCare is only one of many examples she provides of a system in trouble. Many states are cutting back on Medicaid and SCHIP, costs are soaring, the number of uninsured is growing. But all Washington is talking about is the Patient Bill of Rights, which RWJ president Steve Schroeder calls a "version of the Maginot Line."

Tumulty goes back to the election in 1990 of Harris Wofford and subsequent election of Bill Clinton to wonder if a similar political realignment may come out of the current health care quandary.

Source: http://time.com/time/nation/article/0,8599,214063,00.html

LA Times: State Medicaid Train Wreck

The *Los Angeles Times* also writes about the problems states are having in funding Medicaid. The article by Stephanie Simon is excellent on listing the problems, but falls short on suggesting solutions.

She points out Medicaid is a close second to education in state spending. It now covers 40 million people, but two-thirds of its costs are devoted to optional programs not required by the feds. In fact, during the 1990s the states went on a spending spree that included major expansions of their Medicaid programs, in part to access federal matching money.

Now they have discovered they can't even afford their share of the costs. The one example she gives of a state taking positive action is Utah, where the state is dropping some benefits and adding co-payments to others. It also is allowing some low-income workers to buy-in to the program. Of course, the changes are criticized by the Left.

According to the article, Leighton Ku of the Center for Budget and Policy Priorities says, "adding enrollment fees and co-payments ignores 'decades of research that show that co-payments make a big difference in utilization rates.'" Huh?

No, the move to add co-payments doesn't "*ignore*" that fact. Such changes are based precisely on the idea that co-payments *will* change utilization rates. That's the whole point.

Sheeeesh! Thanks to Grace-Marie Turner at The Galen Institute for bringing this article to my attention.

Source: http://www.latimes.com/news/nationworld/nation/la-030502medicaid.story

Price Controls Don't Work

While we're on Medicaid, I wrote an op-ed for Knight-Ridder arguing that state efforts to control prescription drug prices are misguided and counter-productive. Even their attempts to require the purchase of generics has often backfired because of conflicting federal laws that make generics sometimes more expensive than name-brand products.

Source: http://www.showmenews.com/2002/Feb/20020226Comm006.asp

But Risk Pools Do

One positive step many states have taken and others are considering is creation of a high-risk pool. North Carolina could soon join the list, according to an article in the *Business Journal*. The article reports the idea is being advanced by the local health underwriters, but the local Blue Cross plan and HMO association are squeamish about it.

Legislators from both sides of the aisle seem to be supportive of the idea and are proposing a report during the coming session, which begins on May 28. The article looks at a similar successful pool established up in 1990 in neighboring South Carolina. Supporters argue a high-risk pool can lower costs for the remaining population, stabilize the small group and individual insurance markets, and encourage more competition within the state.

Source: http://triad.bizjournals.com/triad/stories/2002/03/04/story2.html

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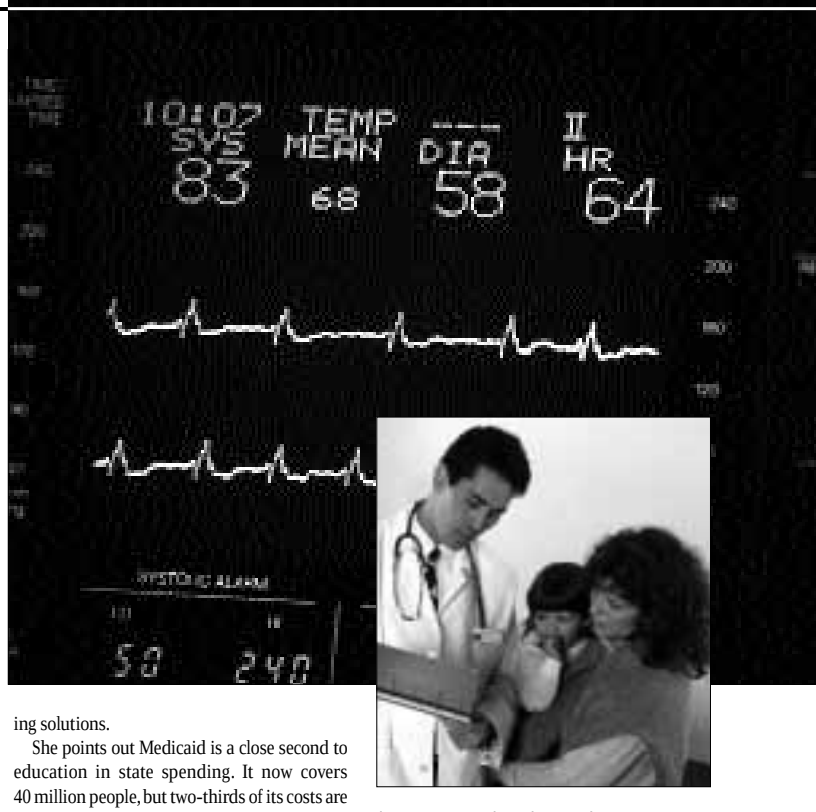
Free-market health care reform in the news



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New Health Threat: Litigation

BY ROGER F. MECUM

Nothing should ever come between a patient and a doctor... and especially not a lawyer. Yet today's out-of-control legal environment is doing just that, denying patients the care they deserve.

Spurred by soaring malpractice awards, runaway insurance rates are forcing doctors to cut back. They have less money to invest in new medical equipment, are forced to close branch offices, and must trim office staff. As a result, fewer health care services are available, and they are of a lower quality than would have been the case in a less-litigious environment.

According to a survey recently conducted by the Pennsylvania Medical Society, 72 percent of doctors have deferred buying new medical equipment or hiring new staff because of sudden increases in liability insurance.

To lower their risk and insurance premiums, doctors who normally would take on high-risk medical procedures are opting not to do so.

For example, scores of obstetrician/gynecologists have stopped delivering babies, because virtually every medical liability insurance carrier has increased their rates. Between January 1997 and September 2001, major liability insurance carriers writing in Pennsylvania increased their overall rates between 80.7 percent and 147.8 percent.

The Market Reacts

Some medical liability insurers are simply not writing policies. Most recently, the St. Paul Cos. announced it would stop selling medical liability insurance products. In addition, several carriers have gone out of business, while others refuse to sell insurance in a state with a reputation for abuse of the medical liability system.

Of 1,098 high-risk specialists polled between December 10 and 17, 2001, 31 percent had been dropped by their insurer.

Driving premiums through the roof are excessive sums awarded in malpractice lawsuits. According to data from the National Practitioner Databank, medical malpractice payments for physicians in 2000 reached $3.9 billion: $3,908,113,303, to be exact.

New York had the highest payouts at $632,996,221. Pennsylvania is second; during fiscal year 2000, combined judgments and settlements in Pennsylvania totaled $352 million—nearly 10 percent of the national total. Florida, Illinois, Ohio, and Texas also experienced payouts of more than $200 million.

> **"According to data from the National Practitioner Databank, medical malpractice payments for physicians in 2000 reached $3.9 billion."**

The Consumer Loses

To make matters worse, the Physician Insurers Association of America (PIAA) reports nearly 70 percent of all medical malpractice claims made against doctors do not result in a payment to the plaintiff. Only 1.3 percent of all claims made against a doctor result in a jury award to the plaintiff.

It costs money to defend doctors against medical malpractice claims—even those that find the doctor not guilty. According to the PIAA, in 2000 it cost $66,767 on average to dispose of a claim that goes to a jury finding the defendant not guilty.

This all adds up to bad news for the public ... and for the business community, which pays for its employees' health insurance. To fend off litigation and cope with steep liability premiums, doctors ultimately are being forced to practice defensive medicine. Research reported in the *Quarterly Journal of Economics* found defensive medicine adds $50 billion to the cost of health care every year.

Reasonable laws that protect patients should be in place. But abuse of the system must stop. Frivolous lawsuits and unreasonable jury verdicts have financially strained the U.S. health care system. Now is the time to act to re-establish the doctor-patient relationship: a uniquely American relationship that provides attentive, quality health care for all.

Roger F. Mecum is executive vice president of the Pennsylvania Medical Society. His email address is state@pamedsoc.org.

END continued from page 1

nine-months'-pregnant wife) are en route to a hospital that stopped doing heart surgery or delivering babies because it could no longer afford the insurance coverage. Not to worry … a state or two over, where the insurance premiums are a bit less, you might still find somebody willing.

What do you tell the driver of your ambulance? "Yes, I know we're in Philadelphia. Now let's head for Cleveland."

Notes Rubin: "Executives at the St. Paul Companies, the country's second largest underwriter of medical malpractice insurance, have notified virtually all customers who are obstetricians, general surgeons, or emergency medicine doctors—the three specialties most likely to be sued—that their policies will not be renewed."

Giving one cause to wonder whether you will even have the option of heading for Cleveland for your emergency, Rubin also notes:

- "Rates for physicians insured by the company in 27 states have increased an average of 24 percent this year."
- "Tillinghast-Towers Perrin, whose clients include malpractice insurers, says doctors can expect rate hikes of 8 percent to 18 percent this year and next—and well above 18 percent in some jurisdictions."
- "One six-member OB-GYN practice in North Carolina, whose insurance had been canceled, found itself paying $277,000 a year for new coverage—more than double what it had been paying."

In "Costs Lead Rural Doctors to Drop Obstetrics" (*Washington Post*, November 23, 2001), John Porretto of the Associated Press notes: "Physicians who specialize in family medicine and obstetrics/gynecology in Indianola and other rural areas of Mississippi are increasingly dropping obstetrics because of skyrocketing costs for malpractice insurance.

"Medical liability insurance rates for doctors who deliver babies have risen from 20 percent to 400 percent this year depending on the carrier, according to the Mississippi State Medical Association. Annual premiums range from $40,000 to $110,000."

In parts of Florida, some doctors paid nearly $160,000 last year for professional liability insurance.

More Trouble On the Horizon

And then there's the mercifully not-yet-enacted "Patient's Bill of Rights," which only expands the lawsuit lottery. In our June 29, 2001 column for WorldNetDaily, "Lawyers Bill of Fights," we warned, "The real outcome of the PBOR (Patient's Bill of Rights) would likely be twice as many suits against twice as many physicians and HMO defendants."

A month later, in our July 27 WorldNetDaily column, "Patient's Bill of Goods," we reported, "The Employment Policy Foundation recently released a study that suggests this kind of legislation could lead to 56,000 new lawsuits per year, $16 billion in higher health care costs, and 9 million more Americans without health coverage."

For years, the diamond-dripping trial lawyers have brazenly proclaimed their only goal was to eliminate medical malpractice. The hundreds of billions of dollars a year headed for their crocodile wallets had nothing to do with it! And we have some oceanfront property in Arizona to sell you … cheap.

Studies indicate that many patients allegedly harmed by medical malpractice, and many winners in the malpractice lottery, weren't in fact injured by malpractice—but were awarded damages because of jury sympathy or other reasons extraneous to fact and justice.

What's the Alternative?

So what to do? Some states, such as West Virginia, are considering special insurance options to keep doctors open for business. And many experts advocate comprehensive tort reform, destroying the web of greed by limiting punitive damages, contingent fees, class-action lawsuits, and overall settlements. But medicine can't wait for that particular miracle.

One alternative may be to require patients, as a condition of treatment, to submit malpractice claims to arbitration. This is common practice in the commercial banking industry. Plaintiffs tend to win more often in arbitration than in court, but the settlement amounts are generally lower, reflecting proper compensation and neither punitive damages nor the antics of "runaway juries."

Another possible alternative comes from the general aviation industry. Over several decades, predatory lawsuits effectively bankrupted the producers of single-engine piston planes. It took years, but a coalition of manufacturers, unions, pilots, and others persuaded Congress to pass the General Aviation Revitalization Act on August 17, 1994—perhaps the first time in history people had organized to demand limitations on their right to sue. It worked, and general aviation has experienced several years of unprecedented growth.

Maybe what's needed is a "General Medicine Revitalization Act." Ask your doctor about it soon … while you still have one.

Michael Arnold Glueck, M.D. writes on health care issues and Robert J. Cihak, M.D. is the immediate past president of the Association of American Physicians and Surgeons. Together they write a weekly column for WorldNetDaily.

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Internet Offers Easy, Illegal Access to Pharmaceutical Drugs

BY CONRAD F. MEIER

Some Internet drug store sites ignore any manner of medical review or prescription authorization. They boldly go where no law-abiding pharmacy would dare to go.

"Worse than the threat of anthrax," one site warns, "is the threat that if a city is attacked, the demand for anthrax antibiotics will cause all pharmacies to run out of stock."

No Prescription Required

The steady media attention given anthrax scares has turned Cipro into a household name, and dozens of Internet sites have come under investigation for illegally selling the antibiotic without a proper prescription.

Law enforcement officials and drug industry experts say the way the antibiotic is being sold is just the latest example of a growing threat to public health.

Online pharmacies selling medication without a prescription, or after only a brief online consultation, are violating U.S. laws meant to ensure the nation's drug supply is safe for patients. Some sell the genuine product, but regulatory officials say many others substitute expired drugs, counterfeit drugs, or sugar pills.

The phony drugs can trigger allergic reactions or cause dangerous interactions with other drugs, health officials say. Internet sites often neglect to screen patients for health conditions that could be aggravated by certain drugs.

Even being cheated of a prescribed medication, substituted with sugar, can have serious repercussions for people who rely on it. In the case of anthrax, the consequences could be deadly if someone takes fake antibiotics.

Cyber Drug Traffic

Illegal sales of prescription drugs have increased over the past few years as the practice of buying medications online has gained acceptability.

Before the Internet, some drug hucksters ran small ads in newspapers or magazines offering toll-free numbers to order prescription drugs. But there really was no fast and effective way to reach a mass public with a scam.

The advent of legitimate online pharmacies unwittingly cleared the way for unscrupulous drug dealers eager to profit from the public's demand for brand-name prescriptions.

Dealers can launch Web sites overnight and reach hundreds of thousands of people by spamming email addresses. They can use false names and addresses. They can shut down sites being investigated by U.S. authorities and quickly replace them with new ones.

Counterfeiting Followed

Among the first drugs to be targeted by illegal dealers was Pfizer's Viagra. In summer 1998, two months after Viagra was approved to treat erectile dysfunction, Pfizer learned Internet sites were selling the drug without requiring a prescription.

Online profiteers violated trademark and regulatory rules claiming to offer drugs "just as good as" as Viagra. Others capitalized on the name by marketing pills called Viagro or Vigra.

Customs officials have intercepted thousands of phony or expired Viagra pills en route to American customers.

"This was a new phenomenon for the industry," said Geoff Cook, a spokesman for Pfizer. "Viagra was such a breakthrough and such a success that we have all these people trying to infringe upon it."

Pfizer's experience was only the tip of an iceberg. Internet sites soon began selling other popular lifestyle-oriented drugs. Over the years, the online pharmacies pushed Xenical for weight loss, Propecia for hair loss, Zyban to help quit smoking, and others.

9/11 Aftermath

Since the terrorist attack on America, Cipro jumped to the top of the list of medications sold illegally on the Internet. It is featured on many of the multi-drug Web sites and promoted more vigorously than Viagra. On other sites, it is the only drug sold, spawning a host of Web sites with the words Cipro or anthrax in their addresses.

Public health officials insist there is no reason to hoard Cipro. The government is creating its own stockpile to respond to emergencies. Bayer, the company that makes Cipro, is adding 200 million pills to the stockpile. Health officials say hoarding will only make a shortfall more likely. Moreover, taking Cipro unnecessarily can create strains of bacteria resistant to antibiotics.

A Global Challenge

Despite efforts to shut down illegal sites and pursue action against those who infringe on trademarks and patents, the problem of unauthorized pharmaceutical sales persists.

According to Tom McGuinnis, the U.S. Food and Drug Administration' s director of pharmacy affairs, illegal sites operated within the U.S. are relatively easy to shut down, an effort that has fallen largely to state regulators and law enforcement. But many of the online pharmacies, even those claiming to have U.S. doctors or U.S. operations, are overseas. In those cases, U.S. regulators depend on assistance from foreign regulators. Some regulatory agencies, especially in developing nations, lack the authority to act.

Know Your Source

Legitimate online pharmacies, such as CVS.com and RiteAid.com, do not issue prescriptions based on online consultations. They operate much as regular drug stores do, accepting prescriptions phoned-in or emailed by doctors. And, they are licensed by state pharmacy boards.

Celebrating over 51 years of innovative healthcare solutions

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We Call it Insurance, But That's Not Healthy

BY LAWRENCE H. MIRÉL

Most efforts to improve the nation's health care finance system involve tinkering with the present insurance-based model. Such efforts are likely to fail in the long run, because insurance itself is the wrong model for part of the system.

An "insurable event"—from traffic accidents to tornadoes—is something that: first, is very unlikely to happen; second, will come without warning; and third, is not something the person who is insured ever wants to happen. That definition applies well enough to such catastrophic health events as serious illness or injury. But it does not apply to routine health maintenance.

A Built-In Contradiction

The current health care system tries to finance both catastrophic and regular health care with one insurance system. This effort contains a built-in contradiction. The insurance system works best when the fewest people use it (i.e. make claims); the health care system works best when the most people use it (i.e. get checkups and tests and vaccinations). The goals are incompatible.

Managed care was developed in an attempt to reconcile these differences ... and that system satisfies nobody.

- Managed care infuriates health care practitioners and consumers when it limits or denies payments on the grounds that some treatment or service is not medically necessary.
- Legislators respond to the public outrage by mandating payment for routine services, whether or not they are really necessary.

"Since employees don't pay for their insurance coverage, and employers don't benefit from generous benefits, the system is designed for conflict and turmoil, for political posturing and lawsuits. It is definitely not designed for providing the best health care at the best prices."

- That, in turn, frustrates insurers, because mandated benefits throw off the underwriting calculations made when the plan was priced, and therefore result in losses or price increases or both.

As D.C. commissioner of insurance and securities, I hear complaints from all quarters.

Third-Party Flaws

There's a second basic flaw with the health care payment system: Unlike virtually any other commodity or service, contracts for health care services are negotiated not by the affected parties—physicians, hospitals, and consumers—but by insurers and employers.

Most health insurance is acquired as a benefit of employment. A worker who gets a job with "health benefits" may not learn just what is covered and what is not until a claim is made—often too late for the information to be useful.

For good and competitive reasons, employers try to find the least-expensive plan they can. Insurance companies know this, and try to hold down costs—either by paying providers less or by covering fewer conditions and services for employees.

Since employees don't pay for their insurance coverage, and employers don't benefit from generous benefits, the system is designed for conflict and turmoil, for political posturing and lawsuits. It is definitely not designed for providing the best health care at the best prices.

Two-Tier Solution

Is universal, government-provided health care the answer? I don't think so. I don't think government can solve these issues any better than private insurers have been able to, and the notion of a monolithic health care system run by government frightens me.

Instead, I would look to more modest changes, but changes that nevertheless go to the heart of the problem.

To begin with, we must recognize we are dealing with two different tiers of health care needs that should be financed through two different payment systems.

One tier is catastrophic illness—and for that tier, insurance is the answer. Policies that carry a high deductible (say, $5,000 a year) are relatively inexpensive, even when the upper limits of the coverage are very high ($1 million or more) or even unlimited. That is because most people do not get catastrophic illnesses or injuries. Such insurance would also cover the cost of any chronic illness treatment that exceeded the deductible.

I recently priced such catastrophic coverage for my 30-year-old son. An individual policy was not much more than $900 a year—less than a quarter of what he would have had to pay for full coverage. Certainly the price would be higher for older purchasers, but high-deductible policies will always be far less expensive than their full-coverage counterparts.

Maintenance and Routine Procedures

The second tier comprises health maintenance and routine medical procedures. For this tier, insurance is not the answer. Instead, I see three possible options.

One is for people to pay these costs out of pocket, the way we now pay for many other routine needs, such as car and home maintenance.

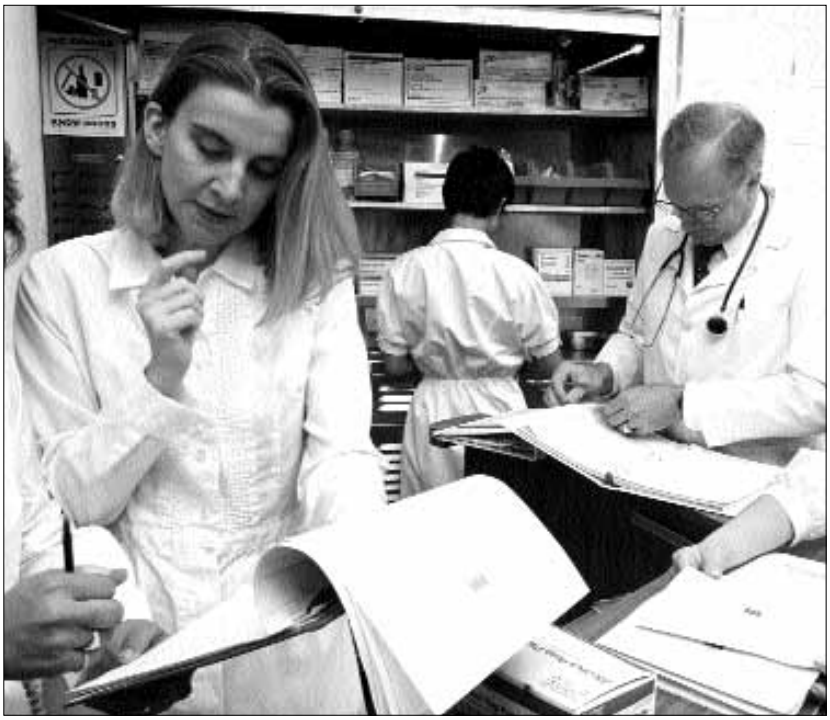
There are all kinds of benefits to this approach, including the prospect of direct negotiations between providers and their patients, no managed care, and less paperwork. For many people, coming up with the cash to pay routine medical bills would not be difficult, especially if they know that any major illness or injury would trigger a backup insurance plan.

For others, however, paying for even routine care would present a problem. Here, an employer-based system could be useful ...but not a system that tries to insure routine health care. Instead, employers might be asked to put money into individual "medical savings accounts" for their employees.

That is, instead of an employer having to renegotiate a health insurance contract every couple of years, trying to determine what should be covered and what should not be covered, the employer would take the money that would otherwise go into the purchase of health insurance and put it in the pockets of each employee.

The employee would then determine how to spend the money—that is, whether to pay for dental care, doctor's visits, alcohol treatment or mental health therapy, or even whether to join a health maintenance organization that would cover those needs.

Federal law makes this an attractive option for small businesses and the self-employed, because medical savings accounts are deductible to those employers and not taxable for employees, as long as the funds are used to pay for health care, defined very broadly. Moreover, the funds can accumulate in the accounts of the employees and roll over from year to year. According to federal law, once an employee turns 65, this tax-free money can be spent on anything its owner wants, not limited to health care. Legislation now pending in Congress would extend these favorable tax provisions to all employers and employees.



"This is what the very largest employers do for themselves. It is the least expensive, most easily administered system. If it works for them, it will work for the rest of us."

The third option would be for those who are not employed and cannot afford health maintenance or routine medical costs at all. The most effective way to cover their costs is to have the government purchase a membership for them in a prepaid health care plan. That is essentially what Mayor Anthony Williams had in mind when he proposed enrolling Medicaid recipients in HMOs.

Tried and True

Rational buyers of health care coverage should free themselves from the current insurance-based model. Instead, they should use the two-tiered system, and purchase a group "catastrophic" health insurance policy for all employees—a policy that would be very inexpensive and would cover all major illnesses and accidents—and use the money saved to help employees pay for routine health care, through medical savings plans or some other form of assistance.

How do I know this would be sensible and cost-effective? Because what I am proposing is not entirely new. This is what the very largest employers—including large health insurance companies—do for themselves, even if their employees aren't always aware of it. They do it for one reason only: It is the least expensive, most easily administered system.

If it works for them, it will work for the rest of us.

Lawrence H. Mirél is the District of Columbia's commissioner of insurance and securities.

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Oregon Community Adopts SimpleCare Approach

More than 60 physicians, the local hospital, and health insurance brokers have boarded the SimpleCare bandwagon

BY KURT T. WEBER

McMinnville, Oregon family physician Mike Jaczko D.O. was struggling to keep his doors open. With high hopes—and more than a little desperation—he attended a lecture sponsored by the American Association of Patients and Providers (AAPP), whose mission is to develop health care solutions.

By implementing AAPP's SimpleCare program, Jaczko was able to reduce administrative costs and offer more affordable health care. His clinic began to stabilize financially.

Jaczko says the SimpleCare program "gave me the motivation to continue working in health care and serve others." His goal now is to persuade city administrators and employers "to switch to this model."

Other local physicians observed his success. Dr. Erik E. Swensson, president of the McMinnville Physicians Organization (MPO), invited AAPP cofounder Dr. David MacDonald to share with MPO members and area business owners ideas for a comprehensive transformation of their health care delivery system.

All 62 members of the McMinnville Physicians Organization became SimpleCare providers.

Keeping it Simple

SimpleCare works on a basic premise: If patients pay for routine medical care at the time of service, the administrative and billing expenses that inflate the cost of health care can be dramatically reduced. Those cost reductions can be passed along to patients. MacDonald says SimpleCare providers "can usually reduce their rates by 30 to 50 percent."

Such cost reduction claims are supported by a 2000 survey sponsored by the Washington State Medical Education and Research Foundation. The survey reported, "Today over 50 cents of every dollar received by medical practices goes to the cost of running the practice and dealing with insurance plan requirements, not to patient care."

Back from Bankruptcy

AAPP cofounder Dr. Vern Cherewatenko, who developed the SimpleCare program, has experienced the success of SimpleCare firsthand. He used to charge patients $79 for a 10-minute office visit, but was reimbursed only $43 by an HMO. After factoring in administrative expenses of $20 and overhead of $30, his practice experienced a $7 net loss for every patient he saw.

Cherewatenko and his Renton, Washington group practice, Primary Care Providers, went bankrupt, and Primary Care Providers filed for Chapter 11 reorganization. In his reorganization plan Cherewatenko says Primary Care Providers "intends to develop the SimpleCare side of the practice until we no longer are in need of insurance company contracts."

Doing so, he says, is the ultimate solution for "trimming the administrative burden that is killing many physician offices today." More than half of Cherewatenko's current patients are SimpleCare members; his practice charges them only $35 for the 10-minute office visit that used to cost $79. Nevertheless, the practice makes a profit of $5 on each of its SimpleCare patients.

> **"To the benefit of health care consumers, some 600 physicians in 38 states have become SimpleCare providers."**

For more information…

WWW visit the SimpleCare Web site at **www.simplecare.com.**

Strengthening Relationships

To the benefit of health care consumers, some 600 physicians in 38 states have become SimpleCare providers. McMinnville's Swensson said SimpleCare is capturing the attention of physicians for reasons other than financial.

"We can spend more time with patients when we spend less time on paperwork," Swensson notes. "Furthermore, insurers can't interfere with the doctor-patient relationship when patients pay for their own services. Final decisions about the kind of treatment and who will give it are made by the patient."

Other health care providers in McMinnville are joining the parade. According to MPO Executive Director Anne Hamilton, Willamette Valley Medical Center, the local hospital, is working to adjust its system to accommodate SimpleCare patients and providers. MPO is also seeking a pharmacy to join the program.

Area insurance agents are working on ways to bring more major medical, high-deductible policies to the community to help individuals, families, and businesses that wish to employ SimpleCare as a way to bring down health care costs.

In doing so, the agents will help return insurance to its original purpose: protecting individuals against unforeseen catastrophic events. As Cherewatenko puts it, "Insure for the big stuff, pay cash for the small stuff—just like you do with your car."

The challenge of making health care more affordable is being met in McMinnville, through the SimpleCare model. Keep your eye on that Oregon community as local doctors and other health care providers work to implement this creative solution.

Kurt T. Weber is vice president of Cascade Policy Institute, a Portland, Oregon think tank.

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Who is Dr. Merrill Matthews?

Merrill Matthews Jr., Ph.D., is a Heartland Senior Fellow specializing in health care policy and a visiting scholar with the Institute for Policy Innovation. Dr. Matthews is past president of the Health Economics Roundtable for the National Association for Business Economics, the largest trade association of business economists, and health policy advisor to the American Legislative Exchange Council, a bipartisan association of state legislators.

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States Delcare War on Prescription Drugs *continued from page 1*

Little Effect on Spending

While the goal of supplemental rebates is to lower a state's cost for drugs under Medicaid, the true effect is simply to shift the cost to other health care consumers and, in some cases, to other government programs. Such cost-shifting is nothing new in health care: Some actuaries argue that those with private health insurance pay about 40 percent more for health care because those in government programs (primarily Medicare and Medicaid) pay less than the actual cost of their care.

According to a study by the General Accounting Office, the original 1990 legislation allowing Medicaid rebates resulted in drug manufacturers lowering the discounts routinely offered to other purchasing groups. Price discounts in the three years following adoption of the rebates fell from 24 percent to 14 percent for HMOs and from 28 percent to 15 percent for group purchasing organizations. Overall, weighted average best-price discounts fell from 37 percent in 1999 to just 19 percent in 1994.

More evidence of the failure of prescription drug price controls can be found in Canada, a country often touted as a model by advocates of supplemental rebates. Tough restrictions on drug pricing there forced drug companies to raise prices and limit discounts on widely used drugs. Wharton professor Patricia Danzon has estimated the average U.S. consumer would spend 3 percent *more* for prescription drugs if he or she lived in Canada. The lower *general* price level of prescription drugs in the U.S. is overlooked by advocates of supplemental rebates who focus on the high prices of only a few new and relatively exotic drugs.

"More evidence of the failure of prescription drug price controls can be found in Canada, a country often touted as a model by advocates of supplemental rebates. ... Wharton professor Patricia Danzon has estimated the average U.S. consumer would spend 3 percent *more* for prescription drugs if he or she lived in Canada."

Requiring additional rebates from drug companies may lower prices for the government, at least temporarily, but those savings would be purchased at the expense of those outside Medicaid programs, including the uninsured and those who have private health insurance. Rising private insurance premiums, in turn, would increase the number of people who cannot afford to buy insurance.

Nationwide, health insurance premiums are expected to rise about 13 percent this year, even without the effects of supplemental rebates. (See "Health Care Spending Rockets Upward," *Health Care News*, March 2002.) Those in the small group and individual health insurance markets are seeing rate increases as high as 40 and 60 percent. Additional cost-shifting through supplemental rebates will exacerbate the problem of rising premiums, and therefore increase the number of uninsured.

Ironically, those priced out of the market for private health insurance because of cost-shifting may find themselves turning to the state for coverage. Like other types of regulation on insurers and health care providers, supplemental rebates are likely to cause greater dependence on government programs and an upward spiral in public health care spending.

A Threat to Health

Limiting access to drugs through restrictive drug formularies limits what doctors can do to protect the life and health of their patients. Guaranteeing that there is a pain medication on the formulary is not the same as ensuring access to the most effective or safest drugs that could relieve a particular patient's pain.

Proponents of supplemental rebates claim doctors can prescribe close substitutes or get special permission (known as "prior authorization") to provide drugs not on the state's formulary. The argument indicates naivete about pharmacotherapeutics (how drugs interact within the body) and doctors' willingness to take on more bureaucratic paperwork. There are at least three circumstances where restrictive formularies can threaten human health.

Off-Label Prescriptions. Doctors frequently prescribe a drug for a medical condition other than the one for which it was approved by the U.S. Food and Drug Administration (FDA), a practice known as an "off-label" prescription. For some diseases, such as cancer, 60 percent of a patient's prescriptions may be off-label.

Some years ago several members of the American Pain Society wrote the FDA about the importance of off-label prescriptions for pain management. The doctors said they frequently used antidepressants for insomnia and pain, corticosteroids for cancer pain, antiarrythmics for neuropathic pain, and beta-blockers for migraine prophylaxis. The flexibility required for these sorts of prescriptions is seriously impeded by restrictive formularies.

Mental Illness. Most drugs are effective for most people with a medical condition for which that drug was approved. Unfortunately, the same cannot be said for diseases of the mind.

Drugs for such diseases as schizophrenia and manic depressive disorder are often effective only for 50 percent of the patients, which means doctors must try other drugs until they find one that works. Limiting drug choices means some mentally ill patients simply won't have the drug they need.

Impact on Minorities. Different ethnic groups may respond differently to different drugs. For example, African-Americans with high blood pressure tend to respond to diuretics much better than whites, and Asians respond to anti-psychotic drugs at a dosage one-tenth that required for whites. For patients with access to virtually all drugs, doctors can switch from an ineffective one to something that works. But formularies limit the number of drugs available, and requiring an additional rebate will exclude even more of them.

Since minority representation in Medicaid is disproportionately high, they are the ones who will bear the brunt of the formulary restrictions.

Ethical Problems

Advocates of supplemental rebates claim the moral high ground in the debate, saying the current drug company practice of charging different consumers different prices based on their willingness to pay is a form of unjust discrimination. But according to Linda Gorman, a health policy expert at the Golden, Colorado-based Independence Institute, "the opposite is true." According to Gorman, price discrimination "is an efficient way to cover high fixed costs, including research and development. Discriminatory pricing also makes everyone better off by maximizing the amount of the product that is produced."

Gorman and other experts contend discriminatory pricing is a common practice in other industries and is efficient so long as consumers are free to choose among competing firms. Advocates of supplemental rebates have demonized drug manufacturers in an attempt to make a "fairness" case for price controls, but this is just new rhetoric for a very old policy recommendation. Price controls, a key part of the failed Clinton health care reform plan of a decade ago, were rejected when it became clear they would cause massive inefficiency and lead to the denial of care to millions of patients. The latest rhetoric can't change the underlying economic principles.

"Limiting access to drugs through restrictive drug formularies limits what doctors can do to protect the life and health of their patients."

Since the people who rely on Medicaid have low incomes, the decision to remove a drug from the Medicaid formulary is essentially a decision to deny access to that drug by the poor. When Florida adopted supplemental rebates in 2001, more than 1,000 of the 1,827 brand-name drugs approved by Medicaid were not on the formulary. It is difficult to imagine a more anti-poor drug policy.

Supplemental Rebate Bills Pending

Arizona	SB 1091
California	SB 697
Colorado	SB 162 and HB 1314
Florida	HB 1353
Georgia	SB 470
Hawaii	HB 1951 (2001) and SB 2519
Illinois	HB 2236 and SB 1308
Indiana	HB 1293
Kansas	HB 2717
Maryland	HB 1186 and SB 550
Massachusetts	HB 2168
Minnesota	HB 2646 and SB 765
New Mexico	SB 253 (signed by Governor)
New York	AB 7557
Ohio	HB 290 and SB 127
Oklahoma	HB 2605 (passed without rebates)
Pennsylvania	HB 444
Rhode Island	HB 5909
South Dakota	SB 196
Tennessee	HB 2089 and SB 2481
Vermont	H 31
Washington	HB 2431 and SB 6368
West Virginia	HB 4666 (sent to Governor)
Wisconsin	AB 841

Source: Center for Policy Alternatives, www.stateaction.org, March 11, 2002 update.

For more information…

WWW See Patricia M. Danzon, "Making Sense of Drug Prices," from Vol. 23, No. 1 of *Regulation* magazine. The eight-page report is available through *PolicyBot*, The Heartland Institute's free online research service. Point your Web browser to **www.heartland.org**, click on the *PolicyBot* icon, and search for document **#3264118.**

Another paper by Danzon, "Can Pharmaceutical Price Regulation and Innovation Co-exist?" is also available through *PolicyBot*. Search for document **#3264114.**

"Coloradans Can't Afford the 'Prescription Drug Fair Pricing Act,'" a paper by Linda Gorman for the Independence Institute, is available through *PolicyBot* as document **#3264125.**

Supplemental Medicaid rebates worsen the growing trend toward a two-tier health care system in the U.S.—one system for the privately insured, and another for those who participate in government programs. Supplemental rebates would be one more in a steady stream of cost-cutting efforts that has included other price controls, restrictions, exclusions, and reporting requirements that compromise the quality of care received by the poor and elderly. Growing numbers of doctors and other health care providers simply refuse to treat Medicaid and Medicare patients due to the price controls and burgeoning paperwork requirements.

Supplemental rebates also open the door for political corruption by requiring drug companies to negotiate with government bureaucracies. Pro-rebate advocates such as the Center for Policy Alternatives claim their proposal "is based on a market approach to pharmaceutical prices" and that negotiations are "voluntary." But

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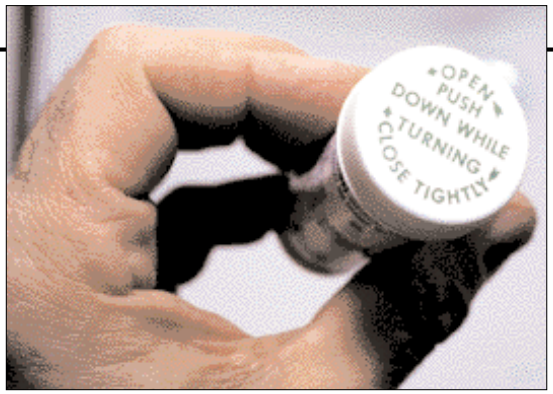
negotiation is hardly voluntary when the state is demanding not only preferential terms in exchange for participation in a government program, but cash payments as well. Such arrangements more closely resemble extortion than public-private partnerships, and they are quite rightly illegal.

Supplemental rebates corrupt the political system in a second way, by allowing politicians to play a kind of shell game that may win votes but is destroying the nation's private competitive health care industry. Politicians promise more and more "free" health care to a growing portion of the population. To pay for it without raising general taxes, which would be unpopular, politicians impose hidden taxes and shift costs through regulation onto providers and privately insured consumers.

The dishonesty of supplemental rebates becomes obvious when the confusing and uncertain label "rebate" is replaced with the much more familiar and accurate label, "tax." Supplemental rebates are taxes on prescription drugs included in a state's Medicaid program. Like all taxes, they raise rather than lower the true cost of the drugs, making them less available to those who need them.



Alternatives to Rebates

The supplemental rebate proposal is a symptom of a dysfunctional health care system that is gradually imploding from government interference and mismanagement. As Rep. Charlie Norwood (R-Georgia) told a meeting of the Georgia Society of Clinical Oncology last October, "every provider, every patient, every hospital in the country is reeling from the same disease: health care rationing, stemming from both managed care and Medicare/Medicaid."

The solution is not further rationing through supplemental rebates, but to systematically reduce government involvement in health care while empowering patients and providers. Across the country, experiments and examples of this alternative reform agenda can be found:

- Medical Savings Accounts allow patients to immediately pay for prescription drugs and health services, and they restore incentives for wellness and price competition in the health care market.
- High-risk pools, such as those in 31 states, offer subsidized private insurance coverage for people with very high health care costs.
- Private patient assistance programs operated by such entities as Mature Rx, AARP, *Reader's Digest*, and Pfizer, provide significant savings to low-income consumers free of charge, and for very modest annual fees for others. (See "Stop Demonizing the Good Guys," *Health Care News*, November 2001.)
- Faster approval of new drugs by the FDA would reduce the cost of new drugs by hundreds of millions or even billions of dollars each year.
- Medicaid reform along the lines of the food stamp program—where participants get a fixed amount of money and are allowed to make their own choices and benefit from being prudent shoppers—would provide the vast majority of low-income patients with an incentive to get value for their money.
- State insurance regulation could be reformed to allow employers to buy personal and portable insurance for their employees, to help avoid the current situation where people become temporarily uninsured when their employment ends.

Joseph Bast is president of The Heartland Institute, publisher of Health Care News. *Merrill Matthews is a visiting scholar with the Institute for Policy Innovation and assistant editor of* Health Care News.

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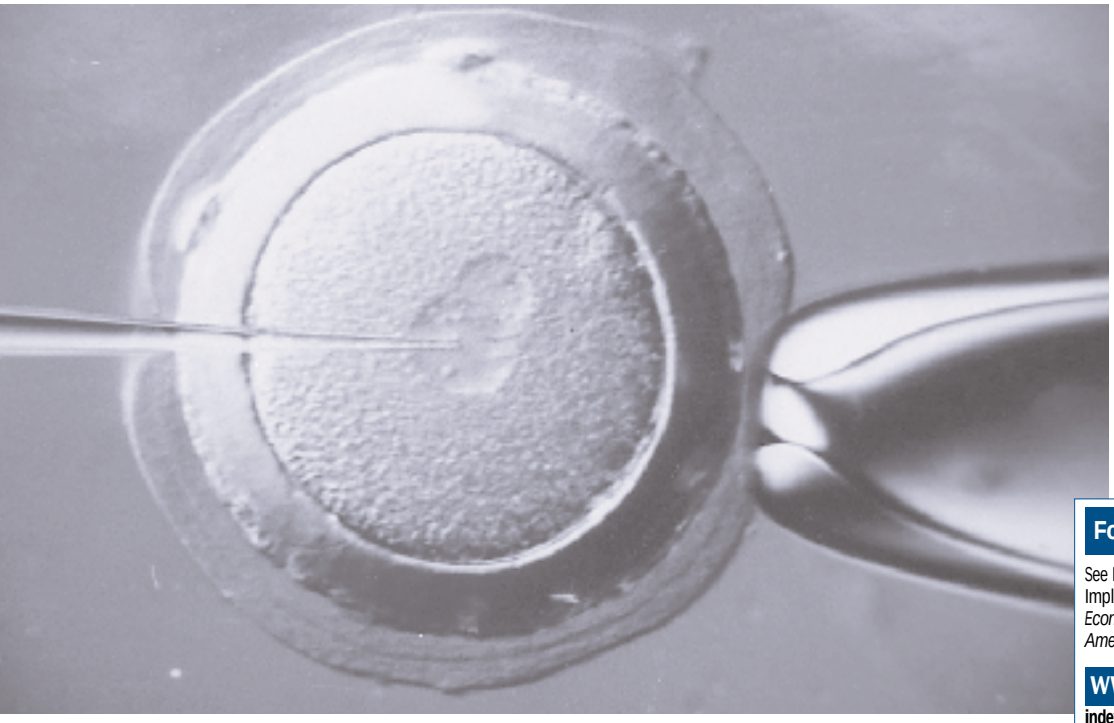

"[W]hile both projects to map the human genome published results in the year 2000, the public-sector effort took 11 years; the private effort, utilizing more modern technology and ample funding, took two years."

For more information…

See Mathew J. Elrod-Erickson and William F. Ford, "Economic Implications of the Human Genome Project," *Business Economics*, October 2000, pp. 57-60; and the *Journal of the American Medical Association*, February 7, 2001, Vol. 285, No. 5.

WWW The Internet offers a wealth of resources on genetics. Among them are *Geneletter*, **www.geneletter.com/index.epl**; *Biospace*, **www.bullmarket.com/1biotech.html**; and *Bio Online Biotechnology*, **www.bio.com.**

The Coming Revolution in Medicine *continued from page 1*

single-gene related diseases, leading to rationally designed drugs to treat them.
- Sequencing the genomes of many disease-causing bacteria and parasites to identify their disease-causing mechanisms.

Through 2020:
- Understanding of the mechanisms of diseases caused by polygenic interactions with environmental factors.
- Routine use of DNA-based diagnostic tools.
- Development of many rationally designed drugs and therapies based on knowledge of gene expression of proteins.
- Therapies based on tissue engineering (e.g., repair of incompetent esophageal and urethral sphincter; regeneration of cartilage in arthritic joints).
- Xenotransplantation of organs from genetically modified cloned animals.
- Gene therapy for single-gene diseases; several hundred diseases may be curable.

Beyond 2020:
- Early detection and prevention will eliminate genetic disorders before symptoms arise.
- Many of the diseases caused by known viruses and bacteria will be prevented or quickly treated.

Some observers anticipate even more rapid progress than that outlined above. One event in our recent history gives a hint of what to anticipate from the biotechnology boom.

After President John F. Kennedy announced the goal of landing men on the moon within 10 years of May 25, 1961, reporters related that NASA officials they interviewed "didn't have a clue" about how to go to the moon. The United States had only primitive computers and rockets, and many thought every scientist and engineer in the nation would have to be drafted into the effort. Based on their current state of technical knowledge, many scientists and engineers were highly skeptical about reaching the goal in twice the time.

Today, many of those in the scientific and medical communities seem to have equal difficulty imagining that technology we don't yet know about, rather than developments based on our current knowledge, will produce the breakthroughs and products we all hope biotechnology will yield.

Presidents Kennedy and Lyndon B. Johnson achieved their goal by managing the budget appropriations process to secure all the funding NASA requested. Similarly, the key to realizing quick results from the biotechnology industry lies in the capital market; adequate supplies of capital to fund private genetic research and development will assure the fastest results possible. Moreover, the private-sector environment presents stronger incentives and fewer constraints than those faced by public-sector enterprise.

Unlike the government's program to send men to the moon, private-sector genetic research and development efforts are aiming at tangible payoffs, can take significantly greater risks, and can field multiple approaches to discovery and product development.

For example, while both projects to map the human genome published results in the year 2000, the public-sector effort took 11 years; the private effort, utilizing more modern technology and ample funding, took two years.

Transformation to Genetic Medicine

It is widely believed that, as more tests for genetic susceptibility to diseases become available, the practice of medicine will evolve from a therapeutic model to a preventive one based on genetics. The new tests will enable detection of common diseases long before patients develop symptoms.

It is estimated there are approximately 4,000 gene disorders. Thousands of tests will likely become available for specific gene disorders and for polygenic predisposition to developing diseases through environmental and behavioral interactions. The availability of tests and possibilities for prevention will stimulate a great patient demand for genetic screening and treatment.

Related developments (e.g., "pharmacogenomics") in genetic medicine will some day enable physicians to tailor drug treatment to each patient's specific genetic makeup to maximize the effectiveness of drug therapy for each patient, as well as avoid adverse reactions. Many biopharmaceutical firms are concentrating on finding the small differences in gene sequences (single nucleotide polymorphisms, or SNPs) between individuals that potentially affect disease progression and an individual's response to therapy. A recent study by Genaissance Pharmaceuticals of 82 individuals found an average of 14 sequence versions for each gene in the human genome.

A pharmacogenomic product exemplifying SNPs is Genentech's Herceptin monoclonal antibody against the Her2 protein. In clinical trials against breast cancer, Herceptin only performed well in a subgroup of patients (about 30 percent) whose cancer cells were found to over-express Her2. As a result, breast cancer patients are now screened to determine whether their tumor cells over-express Her2, because Herceptin is not effective otherwise. Thus, some patients can be given a drug targeted at their particular variant of breast cancer, while the others will not waste time receiving an ineffective drug.

As more "personalized" drugs become available, genetic testing of patients for their responses to the drugs will become a routine part of prescribing pharmaceuticals in medical practice.

Decline of Hospitalizations and Procedures?

Throughout the twentieth century, the distribution of health care expenditures has been remarkably stable. It has been characterized by an extreme concentration of annual expenditures within a small fraction of the population. Throughout the century, only 30 percent of the population has accounted for 90 percent of annual expenditures on health care. About 12 percent of Americans are hospitalized each year, but they spend 40 percent of health care dollars.

Further, less than one-half of the noninstutionalized population have one or more chronic conditions, but they account for 76 percent of medical care spending. Persons with chronic conditions account for 69 percent of hospital admissions and 80 percent of hospital days.

This historically stable distribution of health expenditures could change significantly early in the twenty-first century if, through advances in biotechnology, we are able to prevent or reduce the incidence of some chronic diseases. For example, some researchers and industry analysts suggest the following scenarios are possible:
- Annual expenditures on diseases of the circulatory system comprise about 17 percent of total national health care expenditures. In 1996, 20.7 million Americans had a heart condition (excluding hypertension), and 6.34 million heart-related procedures were performed. Discovery of the genetic origins of susceptibility to heart disease and development of preventive measures for hypertension, atherosclerosis, and congestive heart failure could significantly reduce related hospitalizations and procedures such as revascularization.
- Annual expenditures on diseases of the musculoskeletal system comprise about 6 percent of total national health care expenditures. In 1996, 33.6 million Americans had arthritis and almost 400,000 total knee and hip replacements were performed. Advances in genetic medicine could virtually eliminate the need for surgery in these patients after 2025.
- Lung disease accounts for approximately 7.3 percent of health

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expenditures in the United States. About 15 million Americans are affected by asthma; they generate more than 1.5 million emergency room episodes and 500,000 hospitalizations each year. Because asthma is related to known gene mutations, it is possible that further developments could lead to targeted treatment and prevention by 2025.

- The expanding prevalence of diabetes in the United States has been described as epidemic, expected to reach 23 million in 10 years from about 16 million in 2001. Complications of diabetes, including cardiovascular disease and stroke, diabetic retinopathy and kidney disease, and amputation of limbs account for 10 percent of annual health expenditures, including 25 percent of Medicare expenditures. Type 2 diabetes is a polygenic disorder and accounts for 90 to 95 percent of all diabetes cases. Type 2 diabetes could be preventable within the next 25 years as the disease-causing interactions between genetic predispositions and environmental factors such as obesity and lifestyle are elucidated.

As the predicted advances in DNA-based disease prevention and genetic medical therapies become available over the next quarter-century, a number of procedures in common use today will likely be phased out, as well as the hospitalizations associated with them.

Our experience with public water supply fluoridation may give insight into the potential impacts of advances in genetic biotechnology.

Public water supply fluoridation was initiated in the 1950s to prevent tooth decay in cohorts exposed to it during tooth development. Today, almost two-thirds of the American population drinks from fluoridated public water supplies.

The nationwide prevalence of dental caries—the dental disease that historically consumed the most resources to treat—declined 65 percent in children between 1971 and 1994. The nationwide prevalence of dental caries also has begun to decline in American adults.

The mix of services provided by dentists has changed in response to the changing disease pattern. Between 1959 and 1990:

- The percentage of patients receiving a one-surface amalgam or an extraction fell from 20.1 percent to 5.3 percent, and from 13 percent to 4.9 percent, respectively;
- The percentage of U.S. dental patients receiving an oral examination increased from 20.1 percent to 42.8 percent; and,
- The percentage of patients receiving a prophylaxis increased from 19.9 percent to38.6 percent.

The decline in the incidence of dental caries resulted in a significant reduction in operative procedures, but preventive services increased to take their place. The same pattern could unfold in medical practice as genetic biotechnology provides the means to reduce the incidence and prevalence of genetic-based chronic disease.

Conclusion

The American public will quickly learn of advances in preventive and therapeutic capability, and will likely demand genetic medical services such as screening for disease predisposition and preventive measures.

The measured prevalence of many diseases will rise above current levels because of early detection. The historically concentrated expenditure at the high-cost tail of the distribution of health care spending may dissipate as high-cost episodes of hospitalization and consumption of high cost procedures are displaced by broad-based screening, early detection, and prevention.

Health expenditures will likely be distributed over a larger proportion of the population as the ability to detect predisposition to chronic disease advances and more disease is prevented or is attenuated in severity.

In fact, the number of elderly (age 65 or greater) becoming chronically disabled has already been declining since the late 1980s. This was manifested, for example, in the number of nursing home residents declining by 200,000 during the 1990s. A number of factors are thought to underlie this trend, including fewer people smoking, new drugs for heart conditions and other illnesses, healthier lifestyles, and advances in medical technology. Advances in genetic biotechnology predicted to occur over the next 25 years could accelerate this trend.

Generally, a shift in the paradigm of medical practice from treatment to prevention will occur based on rapidly increasing capabilities of genetic medicine that will significantly change demands on physicians over the next 25 years. However, the exact pace of change is uncertain at this time. It could proceed much faster than some currently predict.

Jesse Hixson is principal economist for the American Medical Association. An earlier version of this paper was prepared for the American Medical Association's Council on Medical Service.

Business Roundtable Rolls Out Patient Safety Survey

Five hundred health care facilities invited to participate, but half decline

BY CONRAD F. MEIER

The Leapfrog Group, sponsored by The Business Roundtable with support from the National Health Care Purchasing Institute, unveiled in January the results of a months-long survey aimed at determining how seriously urban acute-care facilities take the problem of medical errors.

The survey tallied responses from regions of the country specifically targeted by Leaapfrog. While 472 facilities were invited to participate in the survey, 254 declined. The 228 facilities responding to the survey included urban hospitals in California, Minnesota, and eastern Tennessee, as well as facilities in Atlanta and St. Louis.

Leapfrog plans to offer the survey to an additional 1,000 hospitals this year. Any hospital can volunteer to join the study.

Location	# Offered Survey	# Responses	% Adopting at Least One Standard
Atlanta	31	16	56%
California	338	150	52%
East Tennessee	25	23	65%
Minnesota	47	28	39%
St. Louis	31	1	100%

Source: The Leapfrog Group

Survey Design

The participating facilities are invited to complete a Web-based survey and share information with their communities about efforts to reduce preventable medical mistakes.

Survey respondents are asked about their efforts to comply with three patient safety standards considered key by Leapfrog: computer physician order entry, intensive care unit (ICU) physician staffing, and evidence-based hospital referral.

The three principles were developed through an extensive literature review and with input from subject matter experts and health care quality researchers, in partnership with large national purchasers of health care. The group's early research indicated meeting those standards could save more than 58,300 lives and prevent more than 500,000 serious medication errors each year.

Survey Findings

- Only 3.3 percent of hospitals participating in the survey currently meet Leapfrog's standards for computerized prescription order entry. Such systems require physicians to enter a prescription order into a computer using software designed to spot such potential problems as dangerous drug interactions and patient intolerance to the drug. Leapfrog contends employment of such systems could prevent over 500,000 medication errors a year. About 30 percent of the hospitals responding to the survey said they plan to have such systems in place by 2004.
- 10 percent of hospitals surveyed have fully implemented the practice of staffing intensive care units with "intensivists," specialists in this form of care. The Leapfrog Group says at least one in ten patients who die every year in ICUs would have an increased chance to survive if ICU specialists were on hand to manage patient care. About 18 percent of hospitals responding to the survey plan to enlist specialists by 2004.

While the initial findings were discouraging, other responses indicated hospitals were preparing to take steps to reduce preventable medical mistakes, said Suzanne Delbanco, executive director of The Leapfrog Group.

For more information…

WWW on the Hospital Patient Safety Survey, visit the Leapfrog Group Web site at **www.leapfroggroup.org.**

Not Convinced

Several hospital industry associations and individual hospital representatives provided input into the survey design. But in a news release commenting on the survey, the American Hospital Association (AHA), a Washington-based trade group, said it is concerned the approach oversimplifies the complex task of improving quality and seems to suggest a one-size-fits-all solution will work for every hospital in any kind of community.

In the case of computerized physician order entry, for example, AHA notes "this is a promising new technology; however, there isn't an off-the-shelf system for hospitals to buy today. Custom designing such systems is costly and takes time."

High cost is most often cited by facilities that fail to employ technological innovations. Tight-fisted cost controls practiced by managed care firms, along with reimbursement cuts by federal government health programs, have made dollars scarce.

Carmela Coyle, senior vice president for policy at the AHA, said she worries consumers will draw the wrong conclusions from the Leapfrog survey. "The absence of a hospital engaging in the three initiatives doesn't mean a hospital is of lower quality," she noted.

Experience Counts

In addition to encouraging provider facilities to meet its three patient safety standards, The Leapfrog Group also aims to change behaviors in patients themselves.

For example, it encourages patients with complicated medical conditions to seek out hospitals with experience and demonstrated positive patient outcomes. According to Leapfrog, facilities that perform certain procedures often are more likely to perform them better than facilities that only rarely perform complicated procedures.

Patients needing coronary artery bypass surgery, for example, are encouraged by Leapfrog to have that procedure at a hospital performing the operation at least 500 times a year. About 12 percent of the hospitals surveyed have that level of experience in bypass surgery.

The Leapfrog survey found consumers in most urban areas have a choice of hospitals with extensive experience treating patients needing certain high-risk surgeries or neonatal intensive care.

Comprised of more than 90 public and private organizations providing health care and representing approximately 28 million health care consumers in all 50 states, The Leapfrog Group provides information and solutions for consumers and health care providers. Its efforts focus primarily on the quality of certain aspects of care relevant to urban area hospitals.

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English Health Care:

Not Your Cup of Tea

PART 3
IN A SERIES

BY CONRAD F. MEIER

Britain's National Health Service (NHS) was once highly regarded. It was described as "second to none," even "the envy of mankind." Unfortunately, people continued to believe this long after it had ceased to be true, and because they believed it, reform has been difficult.

Political parties and individual politicians alike have had to promise to "protect" the NHS like some historical treasure; they compete with each other on the basis of who can offer it the most money.

Stuck in a Time Warp

Nobody outside Britain praises the NHS anymore. The country is out of step, clinging to central government control and management of health care while other countries move away from a single-payer model towards some mixture of free enterprise and government health care.

Even in Britain, the NHS may no longer be sacrosanct. The situation has gotten so bad people now feel their last hope may be to swallow hard, admit its shortcomings, and embrace changes that recognize consumers have rights and should be allowed to exercise choice.

A recent poll commissioned for the Adam Smith Institute (ASI), the highly regarded London-based think-tank, asked the English about the future of their health care system. Large majorities predicted the publicly funded services will be gone within half a century. Nearly 60 percent think health services will be private "for all or nearly all of the population."

Opinion polls have also established that 82 percent of NHS patients are quite content to receive their NHS treatment in a private hospital. They are satisfied so long as the treatment is "free," and so long as it is good.

This suggests people in Britain might be prepared to see major changes in the ways their health care is offered ... provided it is *improved*, and provided the principle of universal free access is maintained.

Set the System Free

The Adam Smith Institute has called for privatization of the NHS. Specifically, it wants hospitals and clinics, now government-owned, to become free-standing, independent, and self-owned. It wants all consultants, doctors, nurses, and hospital maintenance staff to be employed privately or self-employed. It wants government's role to be limited to the financial side at first, then perhaps phased out altogether.

Plainly, according to ASI, "the NHS has not managed to deliver the high standards expected of it. It is the size itself, and the inability to control all of its parts, which has proved the biggest stumbling block to efficiency."

The break-up of the Soviet Union and its massive army has left the NHS as Europe's largest employer. But although the NHS costs a great deal of public money, national spending on health care is lower in Britain than in any other advanced country. In other countries, citizens spend more of their own money.

General practitioners (GPs) in Britain are already private, in that they are self-employed, performing contract work for the NHS. They were the biggest success of the 1990 health reforms, proving innovative and adaptable in securing improved facilities and better care for their patients. Before the Labour Government changes, the GPs contracting with NHS represented more than 60 percent of patients. Indeed, the reorganization was a recognition of that success, because the Primary Care Groups (PCGs) represent an extension of the autonomy that has worked so well with the GPs.

According to experts at ASI, the problem with the PCGs is that they are too large. It would not be difficult, however, to bring them down to a more manageable size, to act as force behind a redesigned NHS.

The hospitals and clinics could be given the status of independent trusts. They would employ nurses and maintenance staffs, enter into contracts with consultants, and provide care for patients sent to them. This would achieve two objectives: It would make them largely independent of government, and it would offer opportunities for management efficiencies.

Funding Reform

Even if NHS were privatized along the lines proposed by ASI, medical care would remain free, in the sense that it would be paid for by taxpayers rather than patients. In effect, government would be the national insurer (not unlike our own Medicare), collecting money from people in the form of taxes. An outsourced health care provider service, financed out of public funds, would provide much better health care than is available at present, according to ASI.

A further and more liberating stage in the reform plan would include allowing people to choose insurers other than government. Even the government health insurance activity could be separated out and made into an independent national body, working at arm's length from government and in competition with the private sector.

Such changes would result in a new health service, more responsive and offering more opportunity for choice. It would probably cost more, judging by the fact people in other countries seem ready to spend more on health care when they pay part of it themselves. It would certainly provide opportunities to test in Britain the best practices found here and in other nations.

After 50 years of state control, outsourcing promises to take the NHS out of the hands of the politicians and return it to the people.

It is highly unlikely private hospitals would keep patients waiting for 18 months, park them on trolleys in hospital corridors, or even suggest, except in the most unusual cases, they leave the country for medical care. Consumers with purchasing power would seek out the best hospitals. The free market would tell the residents of 10 Downing Street which hospitals are up to par, long before any government study could reach its conclusions.

For more information…

WWW on the Adam Smith Institute and its plans for NHS reform, contact the group by email at info@adamsmith.org.uk.

A Promising Start

In what may have been his most important speech as Health Secretary, Alan Milburn announced on January 15 he intends to give good NHS managers greater autonomy within the system by creating "foundation hospitals."

According to Milburn, successful hospitals will be "liberated" from Whitehall control, while charities and the private sector will be given the chance to take over facilities that fail.

NHS managers of designated "three-star" hospitals will be invited to set up not-for-profit companies to run their trusts free from government interference. Although they would still be subject to national standards and external inspections, managers would otherwise be given complete independence in all other areas, including staff pay and conditions.

"Nobody outside Britain praises the NHS anymore. The country is out of step, clinging to central government control and management of health care while other countries move away from a single-payer model."

In an interview with *The London Times*, Milburn described the NHS as Britain's last socialized industry, "where patients must be grateful for what they receive."

"That model," says Milburn, "is untenable for the twenty-first century. The NHS has to grow up and be part of this century rather than the last. The job of government should not be to run the system but to oversee it. We want greater community ownership and less state ownership, leading to greater diversity and plurality in local services."

Milburn's speech to the New Health Network in London reflects the thinking of public policy analysts from ASI and the Centre for the New Europe in Brussels. Milburn says the idea came from the chief executives of the best hospitals, who told him they wanted greater freedom than proposed under the "earned autonomy" reform devised by the Blair administration.

"We must redefine the NHS from a centrally run,

ENGLAND continued on next page

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Hippocratic Hypocrisy

BY DRS. MICHAEL GLUECK AND ROBERT CIHAK

Managing Editor's note: The American College of Physicians/American Society of Internal Medicine—a key participant in the Medical Professionalism Project described below—will meet in Philadelphia on April 11-14. The group's proposed charter will be discussed in a a special session on April 12, PN 042-Medical Professionalism: Does a Physician Charter Make a Difference?

Hippocrates was a Greek physician. His name graces the Hippocratic Oath that, among other things, obliges doctors to "do no harm" and to place the patient's welfare before their own.

"Hupokritos" was the Greek word for "actor." Our English term "hypocrite" derives from it.

That said, we introduce you to the "Medical Professionalism Project," an international group of physicians and others who recently published in the *AMA Annals of Internal Medicine* and the British journal *Lancet*, "Medical Professionalism in the New Millennium (MPNM): A Physician Charter."

As to whether this product of their collective wisdom may be described as Hippocratic or hypocritical ... well, hypocrisy has been described as the "tribute vice pays to virtue."

Barriers to Social Justice

The Charter's premise seems virtuous enough: It defines the doctor's role as "placing the interests of patients above those of the physician, setting and maintaining standards of competence and integrity, and providing advice to society on matters of health." No problems there.

The Charter then asserts the fundamental guiding principles of the medical profession should be "primacy of patients' welfare," "patients' autonomy," and "social justice."

Now, two outa three ain't bad. But the final item—"social justice"—is a nebulous, high-sounding phrase that the left drags around to justify almost anything they care to advocate or undertake. It leads the group to recommend a set of "reforms" (another all-purpose obfuscation) far more hypocritical than Hippocratic.

The Charter speaks of the need to "reduce barriers to equitable health care." Why everybody should receive the same medical treatment eludes us, but we press on.

Whence cometh the "barriers" the Charter seeks to address?

From poverty, certainly. That's why doctors used to do charity work and lowered their fees as a matter of routine professional obligation and personal fulfillment.

But today, the greatest barriers are institutional. One is an imploding, employment-based health-insurance system. Another is the HMO system, a bizarre perversion of capitalism in which money is made by withholding goods and services.

And yet another is the government, which bureaucratically rations and denies care in a manner best described as "Franz Kafka Meets Alice in Wonderland," and which is always on the verge of going broke.

Not Likely

If the Medical Professional Project really wants to lower barriers, it might consider returning real power to both halves of the doctor-patient relationship. That "reform," however, does not rank high on the Project's priorities.

"While meeting the needs of individual patients," the Charter states, "physicians are required to provide health care that is based on the wise and cost-effective management of limited clinical resources. The physician's professional responsibility for appropriate allocation of resources requires scrupulous avoidance of superfluous tests and procedures" because this "diminishes the resources available for others."

An obvious question arises. How is a physician to know what is or isn't available for "others"? Who are these others? Are they out in the physician's waiting room, or 3,000 miles away?

And who is to tell the physician what is or is not in short supply, beyond the scope of his or her own practice? The government? The insurance companies? The HMOs? We've had a half-century's worth of experience in how they make these decisions, and the welfare of patient or doctor never seems high on their list of priorities.

Why Scarcity at All?

And yet another question arises: Why should there be chronic scarcity of health care at all?

In a market system, when people want more of something, they usually get it. There is no inherent reason why the health care system cannot deliver medical abundance, save for the manufacture of scarcity by organizations, institutions, and individuals whose agendas—be they getting rich or getting re-elected—always seem to trump the free and proper practice of medicine.

Finally, the Project's new breed of medical professionals would have a "commitment to honesty with patients" when errors or accidents occur, the better to preserve "patients' trust." No quarrels there. But the Charter also speaks of "societal trust" based on "reporting and analyzing medical mistakes" to provide "the basis for appropriate prevention and improvement strategies." Strategies strategized by whom, and toward what economic, legal, and political ends?

Once again, we find ourselves offered a spurious "social justice" that requires addressing inequities the reformers themselves have created and still countenance. Not a bad definition of hypocrisy in action.

As for Hippocrates, he understood very well that social justice in medicine is best achieved one patient at a time, in the privacy and autonomy of a unique relationship. He would no doubt have agreed that letting governments, corporations, and miasmic humanitarians dictate the terms of that relationship would violate his Oath.

It would, indeed, do harm.

Dr. Michael A. Glueck writes extensively on medical issues. Dr. Robert J. Cihak is the immediate past president of the Association of American Physicians and Surgeons.

ENGLAND continued

monopoly provider of services and give people the freedom to provide better standards of care for NHS patients," Milburn said. "We now have a clear set of frameworks and standards in place, it is time to let go."

"They put it to me very forcibly," said Milburn. "If they are as good as we all agree they are, why couldn't they become independent not-for-profit institutions with an annual cash performance contract and face no further forms of management from the center?"

No Slam-Dunk

Milburn's proposals will inevitably infuriate trade unions and some socialists. "I recognize that in some quarters this will be extremely controversial. But people should take a small step back and realize that in any other European country this would be regarded as the norm, not the exception. I cannot run a million-strong health service from my office in Whitehall, nor should I."

"Star ratings" were introduced for NHS trusts last September. Only 35 hospitals won a three-star top rating, while 12 were zero-rated. Five of the 12 were given three months to show clear signs of improvement. If they do not, their management and ownership could be taken over by charities or the private sector.

The proposal for "foundation hospitals," which may require enabling legislation, is also likely to be extended to primary care trusts, the new GP-led groups, set to take control of 75 percent of the NHS budget. The model will be similar to our own Independent Practice Associations/Organizations (IPAs/IPOs), which are independent of tight-fisted managed-care control.

Milburn says his officials are examining a legal and financial framework for the new system. Draft proposals are expected to be published this month.

Achilles Heels

The Health Secretary has made a point of stating the foundation trusts would remain within the NHS and denies any suggestions they would lead to the creation of a "two-tier" health care system.

"In some cases you will have old-style hospitals," said Milburn, failing to note "old-style" means long waits and rationing. "Elsewhere, he says, "you will have the private sector coming in to run NHS services for NHS patients."

All of this NHS reform, when and if implemented, is supposed to be held together by a common set of values about care being offered under a "common set of standards"—some would say "one-size-fits-all"—and "largely free of direct consumer cost"—some would say "we still believe in free lunches."

Next in the series: Summary, conclusions ... and it can happen here!

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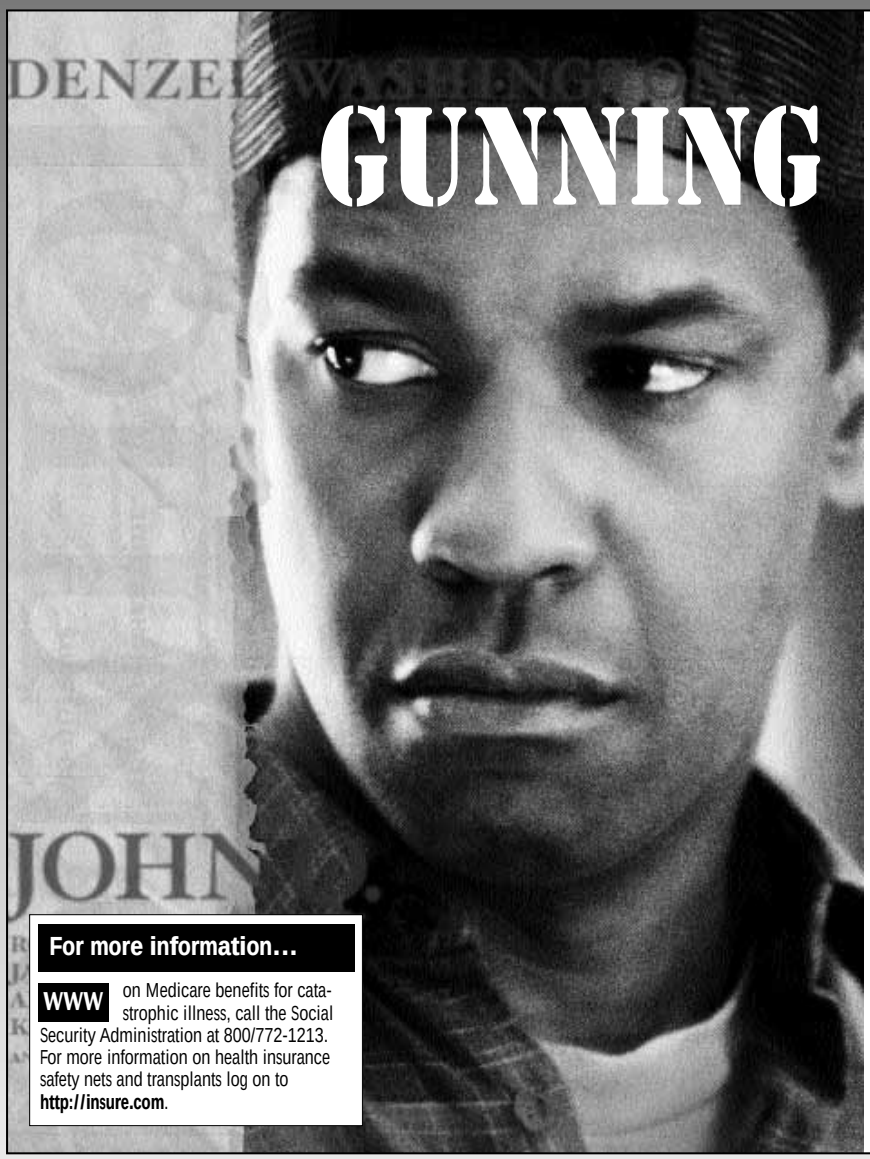

GUNNING THE HMOs

How much of John Q is true?

BY VICKI LANKARGE

In the new movie *John Q*, an HMO bureaucrat played by actress Anne Heche refuses to place the main character's son on a waiting list for a heart transplant because his underinsured family can't come up with the downpayment on the $250,000 operation. She urges them to take the boy home and make what remains of his life comfortable. "People get sick," she says. "They die. That's the way it goes."

Fact or Fiction?

Health insurers are Hollywood's hottest new villains. But the managed care backlash that fuels this movie's momentum (*John Q* takes the hospital's emergency room hostage at gunpoint) is something of a paradox.

A 2001 study by Harris Interactive found that while people say they dislike managed care, most consumers also say they are happy with their own health plans. How can that be true if—as this film suggests—health insurers are routinely denying care to catastrophically ill patients because they don't make enough money and lack the right coverage?

Some say it's because most people enrolled in health plans are healthy. "I'd bet if you interviewed people who have a chronic illness and use their health plan much more often than healthy people, you'd find very different numbers in the satisfaction category," says Richard Sorian, a senior researcher with Georgetown University's Institute for Healthcare Research and Policy.

Hollywood Distortion

Could it be that the health insurance industry works better than the public's perception—and Hollywood's latest stinging portrayal?

That's exactly what the BlueCross and BlueShield Association (BCBSA) is saying. There are dozens of organizations in the United States that work with the catastrophically ill or injured and transplant patients, according to BCBSA Chief Medical Officer Allan Korn.

For more information…

WWW on Medicare benefits for catastrophic illness, call the Social Security Administration at 800/772-1213. For more information on health insurance safety nets and transplants log on to **http://insure.com**.

Missouri Proposal Would Give Patients Choice

BY KATHRYN HANDLEY

Under a bill introduced earlier this year in the Missouri State Senate, HMOs would be required to accept into their network any qualified health care provider.

The Missouri senate's only physician, Marvin Singleton (R-Joplin), sponsored the measure. He says it would allow patients to continue seeing their preferred physician, even if their HMO plans change.

"What we're dealing with in this bill is an attempt to say, 'folks, we need to look at the issues of patients' safety, quality, satisfaction and choice,'" says Singleton.

Cost Implications

Legislative research staff have estimated Singleton's bill would increase the cost of providing health care coverage to Missouri workers by as much as $11.4 million.

Singleton thinks the research staff estimate is too high. Including more doctors in managed care plans would foster competition, he says, which would result in lower costs.

Catherine Edwards, executive director for Missouri Association of Health Plans, disagrees. She estimates patients' premiums would rise between 15 and 29 percent if the bill were passed, because HMOs could no longer reject health care providers with histories of expensive services.

Blue Cross/Blue Shield of Missouri also considers the bill likely to increase costs. Under the bill, notes BC/BS spokeswoman Deborah Wiethop, providers could no longer control competition by negotiating discounts with HMOs.

BC/BS is one of 16 health insurance organizations in the state-sponsored employees group health plan known as the Missouri Association of Health Plans. BC/BS serves 2.3 million people statewide, and a large number of its members are in the Columbia-Jefferson City area, making the firm a potent lobbying force.

Choice, Continuity of Care

One important reason for introducing the bill, Singleton says, is to give choices to rural Missourians, including his constituents in Joplin. HMOs in such communities offer little choice, especially among specialists, because so few practice in rural areas. "Patients aren't getting what they're paying for," Singleton says.

Consumers in that situation can already purchase policies that include all health care providers, notes insurance agency owner James Coyne. Not many do, of course, because the cost is higher and benefits may be limited. Nevertheless, Coyne thinks the existing plans are to the consumers' financial advantage, because the health care providers agree to a pricing structure upfront.

But nurse-practitioner Beth Lonberger of Urology Consultants shares Singleton's concern about patients' continuity of care. Too often, she says, a patient is forced to change physicians in mid-treatment because a doctor once covered by the patient's plan is no longer on the list of authorized providers.

"If they have to move to a different physician, the continuity of their care can be greatly interrupted," Lonberger says.

> **"[A] bill introduced in the Missouri State Senate would allow patients to continue seeing their preferred physician, even if their HMO plans change."**

BC/BS spokeswoman Wiethop says her plan members would not necessarily have to change doctors. According to Wiethop, the firm looks at cases on an individual basis. "It's not a guarantee, but we would be willing to look into it."

After a minor amendment, Singleton's bill was placed on the informal Senate calendar. Though tabled for now, Singleton hopes it comes up again for discussion soon.

Kathryn Handley is a reporter for the Columbia Missourian *newspaper. Email mail@mdn.org.*

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"It's inconceivable that a health care professional would not be assigned to the characters in this movie to assist them clinically, as well as locate financial assistance and other support," says Korn.

Patricia Kolff, director of the National Transplant Assistance Fund (NTAF), disagrees. "Dozens [of organizations]? Who are they?" Kolff asks. "There are certainly disease-specific organizations that offer support, but extremely few that offer financial assistance on a nationwide level. No doubt about it, it is a reality that some people cannot receive a transplant if they do not have appropriate financial coverage."

Are You Covered?

While debate rages around how much of *John Q* is true, do you know what *your* health insurance plan would cover in the event you or a family member needed treatment for a catastrophic illness or injury, or a transplant? If you're tempted to think it can never happen to you, consider this: You have a one in five chance of becoming disabled due to an accident or illness, according to the U.S. Census Bureau.

Unless you're one of the 39 million Americans who are uninsured, you and your family have health insurance through an employer, a government agency such as Medicare, the military, or an individual health insurer. Benefits under such policies can vary greatly and they depend on a variety of factors, including state laws.

Additionally, consider these facts:

- Insurance caps: Many health insurance policies place a limit on the total amount of money they will pay out during your lifetime. After you have reached the limit (typically $1 million, but it can be much less), you have no more insurance. From then on, you are financially responsible for your treatment. Some policies also put caps on how much they will pay for a specific procedure or treatment.
- Experimental procedures: Many health insurers will not cover certain transplant procedures or treatments for catastrophic illness or injury that they consider "experimental." Make sure when your doctor prescribes a treatment that it is covered by your health plan before you receive the treatment. If your health insurer won't cover the procedure or treatment, you have the right to appeal.
- Loss of health insurance: Once people become seriously ill or injured, their problems are often compounded by the loss of their health insurance. Some lose their health insurance when they lose their jobs and are not eligible for continued coverage under COBRA. Others can't afford to keep paying their premiums because their medical conditions are so expensive.

Programs for Help

- High-risk health insurance pools: High-risk health insurance pools are special programs created by state legislatures to provide health insurance for people who can't get coverage anywhere else. Each state operates its high-risk pool differently, although many share common features.
- Medicaid: Medicaid is a jointly funded federal-state health insurance program that covers approximately 36 million low-income individuals, including families with children, the elderly, the blind, and the disabled. Some states also have a "medically needy" program in which Medicaid eligibility is extended to higher-income patients who have high medical costs.
- Medicare: Medicare is a federal health insurance program for people age 65 or older, certain younger people with disabilities, and patients with end-stage renal disease. According to the Centers for Medicare and Medicaid Services, Medicare serves about 40 million beneficiaries.

"A 2001 study by Harris Interactive found that while people say they dislike managed care, most consumers also say they are happy with their own health plans."

Who Else Can Help?

Even when you have insurance, it's easy to underestimate the huge burden a catastrophic illness or injury can put on your financial resources. There are often lifelong costs associated with these, including prescription drugs, and often-overlooked costs, such as travel expenses for treatment and possibly lodging for those who have to visit transplant centers out of their normal driving range.

Many patients wind up mortgaging their homes and using loans and their savings to subsidize their medical treatment, according to Kolff, who co-founded the NTAF in 1983 with her husband, cardiac surgeon Dr. Jack Kolff.

Based in Pennsylvania, NTAF provides a variety of services to patients who need transplants and those suffering from catastrophic illness or injury, such as brain damage suffered in a car, sledding, or diving accident.

The nonprofit organization offers modest ($1,000) medical-assistance grants to eligible candidates to help offset immediate treatment-related costs such as relocation, medications, home care, and transportation. It also helps patients establish restricted "transplant" accounts that allow contributions to remain tax deductible to the extent of the law. NTAF administers these accounts and retains four cents of every dollar raised to defray general office costs and to implement patient services.

Since its inception, NTAF has raised $17 million for patient assistance. According to Kolff, about 2,000 people request information from the organization each year and approximately one in five begin the fundraising process. If a patient dies before receiving an organ, NTAF retains the funds for grants to other patients.

Kolff estimates NTAF is currently serving 700 patients who are fundraising for their heart, heart-lung, lung, kidney, liver, pancreas, bone marrow, and stem-cell transplants, as well as catastrophic brain and/or spinal cord injuries.

Patients and their families shouldn't be afraid to ask for help, says Kolff, and they should pursue every avenue available for assistance. Hope is also important, even when the financial safety nets are failing. "Everyone has some support system available to them," she says. "It's just a matter of helping them to identify it."

Vicki Lankarge is a health reporter for insure.com, the Consumer Insurance Guide.

More Troubles for TennCare

BY CONRAD F. MEIER

The federal government's unwillingness to meet Tennessee's request for $13 billion over three years for TennCare could mean the end of the state's Medicaid managed care program and force the state to return to traditional Medicaid, a state official told the *Memphis Commercial Appeal*.

Health Care News has been following the troubled state government-run health care experiment since March of last year.

Reports indicate the Centers for Medicare and Medicaid (CMS) is offering only $12 billion for the three-year waiver the state is seeking for TennCare, which now covers 1.4 million people.

"If we don't get close to $13 billion over the next three years [beginning in 2003], we will have no choice but to significantly reduce the program," Deputy Finance Commissioner John Tighe said.

He explained the additional $330 million per year is needed to fund Gov. Don Sundquist's (R) proposal to split the program into three parts and reduce benefits to beneficiaries with higher incomes. Because negotiations with CMS are going "so badly," Tighe said the state is "crunching the numbers" on dropping the managed care aspect of TennCare and returning to fee-for-service Medicaid.

The dismantling of TennCare would leave 400,000 people, ineligible for standard Medicaid, without health coverage.

No More Favored Status

Speaking before the State Senate Commerce Committee, Tighe told lawmakers Tennessee would have a better chance of obtaining more federal funding if Sundquist's proposal, which attempts to address some concerns federal officials have raised about TennCare, was approved by the legislature.

What the federal government is looking for is coverage to an expanded population of low-income people using the resources and capabilities of the private-sector insurance market. The federal government also seeks to have Tennessee reform TennCare so companies are not allowed to dump their high-medical-risk employees into the program.

For more information…

WWW on the troubled history of TennCare, see the following articles in past issues of *Health Care News:*

"Tennessee Taxpayers Revolt" and "Tennessee Tax Protest: A Report from the Frontlines," August 2001;

"High-Risk HIP Will Return to Tennessee," October 2001;

"Tennessee Employers May Face 'Play or Pay,'" November 2001;

"More Trouble Ahead for TennCare," December 2001; and

"TennCare Reform Moves Ahead," January 2002.

Tighe told the *Commercial Appeal* that even if the state returned to traditional Medicaid, the savings might be minimal because of administrative costs related to the switch to fee-for-service and the loss of funding for several treatments—including mental health services—the federal government currently helps subsidize.

While state officials are still negotiating with CMS, State Senator Jerry Cooper (D) said the days of Tennessee receiving preferred treatment from the federal government are over.

In the past, favored treatment may have been due to the influence of the current CMS administrator, long-time Republican health care advisor Tom Scully. At the February meeting of the National Association of Health Underwriters, Scully claimed he has "always been a fan of TennCare."

But Cooper thinks Tennessee is not likely to get any more funding than other states, unless Sundquist and Sen. Bill Frist (R-Tennessee) make a personal plea to President George W. Bush for the additional $1 billion.

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State Legislative Update

COMPILED AND EDITED BY CONRAD F. MEIER

GEORGIA

A bill (SB 470) introduced by State Sen. Jack Hill (D) would create a prescription drug discount program for Georgia residents age 55 and over. Drug manufacturers who sell medications through state-supported programs, including Medicaid, would be required to pay rebates to the state Department of Community Health. The state would use the rebate money to reimburse pharmacies, which would in turn give drug discounts to residents. Georgia already receives about $185 million each year in rebates from drug companies through Medicaid, according to State Rep. Ron Stephens (R).

ILLINOIS

Gov. George Ryan (R) announced a $52.8 billion fiscal year 2003 budget proposal cutting Medicaid provider reimbursements and closing a mental health center. Following cuts in Medicaid spending over the last few months, Ryan's latest proposal calls for $756 million in additional cuts, reducing payments to doctors, dentists, pharmacists, and nursing homes participating in Medicaid.

The Illinois budget plan also uses the tobacco settlement and federal funds for spending on additional health benefits for seniors, including prescription drug assistance.

INDIANA

Gov. Frank O'Bannon (D) announced $6.5 million in cuts to the state's CHOICE program, which provides home health care to the elderly. That decrease is part of overall cuts of $109 million O'Bannon made to cover the state's $1.3 billion budget shortfall. O'Bannon previously had announced a $250 million cut from the state's Medicaid program, which has grown by 48 percent over the past six years.

Further cuts to Medicaid are possible. O'Bannon said he will find ways to trim an additional $203 million from the overall state budget in order to reach total cuts of $782 million. The cuts take effect this July.

Prescription drug benefits and eligibility for the state's senior drug program, HoosierRx, would expand under amendments attached to SB 107, which reauthorizes the state's prescription drug advisory committee.

The bill, proposed by State Rep. Vaneta Becker (R), increases the minimum annual drug benefit from $500 to $1,000 and the maximum from $1,000 to $2,000. The bill expands eligibility from 133 percent to 200 percent of poverty and calls for the state to apply for a Medicaid waiver to cover the drug costs of additional seniors, as well as to seek rebates from pharmaceutical companies.

NEW JERSEY

Gov. James McGreevey (D) released a proposal imposing deep cuts in health care spending to counter a $2.9 billion state budget shortfall this year. The budget plan calls for cutting $22.5 million in Medicaid reimbursements to providers. The plan would use $740 million from last year's budget surplus; $50 million from the Disabilities Fund; $30 million allocated but not yet spent by the Senior Gold program, which helps cover the cost of seniors' health care; and $11 million from the Medical Malpractice Recovery fund. McGreevey is also counting on saving $327 million by skipping payments to health and retirement funds for state employees.

NEW MEXICO

The legislature closed the 2002 session passing three of the governor's six policy priorities for reforming the drug war in his state. Gov. Gary Johnson (R) was pleased the legislature passed measures preventing abuse of asset forfeiture laws, allowing offenders to receive Medicaid assistance after release from prison, and giving judges more discretion in sentencing nonviolent habitual users.

Johnson regretted the legislature's opposition to legalizing medical marijuana, decriminalizing possession of small amounts of marijuana, and sending nonviolent first- and second-time offenders to treatment centers instead of prison.

PENNSYLVANIA

Gov. Mark Schweiker's (R) budget plan for the next fiscal year would close a loophole in the state's Medicaid law, which would drop about 7,500 people from the program and save the state about $10 million. Currently, all children with disabilities are allowed to receive benefits through the state's Medicaid program, called Medical Assistance, regardless of family income.

Under Schweiker's proposal, the state would allow children with disabilities to receive Medicaid benefits only if their annual family incomes do not exceed $100,000 for a family of four.

VIRGINIA

The state House and Senate each released budget plans for the next fiscal year. Although very different, both proposals signal the state is poised to ration government services. The Senate plan is more generous than the House plan concerning services to those with mental illnesses. The Senate would restore cuts proposed by former Gov. Jim Gilmore (R) to community-based care programs for the mentally disabled.

WASHINGTON

Under a bill (SB 6368) passed by the Senate, the state would create a list of "preferred" drugs for many common illnesses and use that list to "negotiate lower prices with drug manufacturers." The bill is aimed at reducing the state's $1 billion drug costs during the current two-year budget cycle. In year one, the preferred drug list would apply only to 500,000 Medicaid beneficiaries; thereafter, local governments, private companies, and uninsured residents could participate in the new formulary.

The bill, which still has to pass the House, calls for a panel of doctors and pharmacists to compare similar drugs and choose the cheapest one to put on a list of drugs the state will buy in bulk. The bill would permit doctors to prescribe drugs not on the list. The bill would "eventually" replace a similar prescription drug program that took effect this month.

That program, called "Therapeutic Consultation Service," limits Medicaid beneficiaries to four brand-name prescriptions per month. If a patient attempts to fill a fifth brand-name prescription in a month, the pharmacist contacts the beneficiary's physician, who must contact a pharmacist hired by the state for approval.

WISCONSIN

Gov. Scott McCallum's (R) proposed budget plan for fiscal year 2003 would eliminate funding for 14 community health centers that provide care for low-income and uninsured people. The clinics have received funding from the state only for the past three years, and McCallum's budget proposal would cut $3 million in state support next year, leaving the centers reliant on federal support alone. Community center officials have complained that federal aid is not guaranteed, leaving them in a precarious financial position.

The State Legislative Update is compiled from a wide range of news sources, including the Council for Affordable Health Insurance (CAHI) http://www.cahi.org; the National Association of Health Underwriters (NAHU) http://nahu.org; Bizjournals at http://bizjournals.com; Stateline at http://stateline.org and Lexis/Nexis research.

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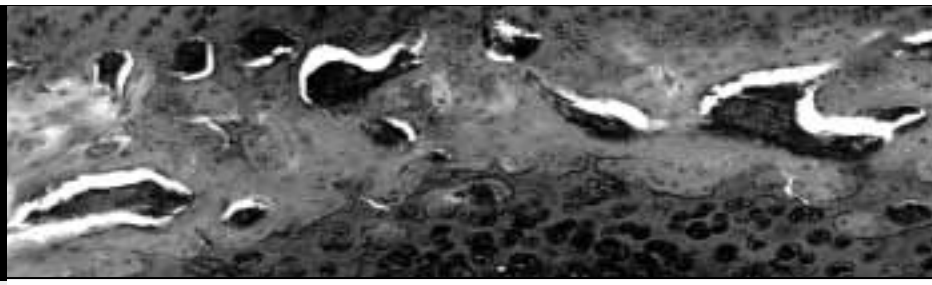
A monthly review of health policy matters



Economists got as exercised as they ever do over whether tax credits or expansion of Medicaid would be the best way to help the uninsured get health coverage. The battle is clearly engaged and, in the arcane world of economics, the ammunition in this battle is over "modeling assumptions." Arcane, but important.

The Kaiser Family Foundation is funding an analysis by MIT Professor Jonathan Gruber and colleagues, allegedly "comparing" the impact and costs of tax credits or expanding Medicaid. While not actually a comparison, it shows Medicaid expansion for people up to 200 percent of poverty would cost $11.3 billion and cover 3.8 million more people, while tax credits (of their own design, not those in President Bush's proposal) would cost $4.5 billion and add coverage to 1.6 million Americans. (Treasury says the President's plan would extend coverage to 6 million people.)

The Medicaid expansion supporters didn't seem to notice that the nation's governors were in town this week practically screaming about their soaring Medicaid costs. For example, New Mexico has the highest uninsured rate in the country, yet the state is about $50 million short in being able to finance Medicaid for current recipients next year. Adding millions of working Americans to Medicaid rolls appears neither politically nor financially feasible.

During a seminar sponsored by the Alliance for Health Reform to analyze the study, economists dueled over the Kaiser report's conclusions, based upon their assumptions of how the world would work if either of these policy changes were implemented, such as how much a policy would cost and how many people would use tax credits.

One economist explained economic assumptions this way: Two economists are stuck in a hole and trying to figure out how to get out. One "assumes" a shovel; the other, a ladder. Unfortunately, in the case of the draft Kaiser study, these economists came closer to assuming a shovel when it came to modeling tax credits and a ladder for their Medicaid expansion idea.

A day after the seminar, one of the Kaiser authors, Dr. Judy Feder of Georgetown University, and I were on the same panel testifying before the House Energy and Commerce Subcommittee on Health. I presented arguments for tax credits, explaining how the current system so badly discriminates against lower-income working Americans and their families and that tax credits are a way to provide some measure of equality to help the uninsured get private health coverage. Links to my oral testimony (the Cliff Notes version) and to the full testimony are provided below.

Dr. Feder presented the findings of the Kaiser study in her testimony. "Thank God for Medicaid," one Democrat exclaimed, echoed by Dr. Feder. Yet, during the hearing, we also learned that the average Medicaid recipient is on the program for only five months—clearly not stable coverage. And we learned recently that in California, only about half of doctors will even see a Medicaid patient. Nonetheless, several Democrats used their opening statements to pledge allegiance to a single-payer health care system.

During the questioning, I did have a chance to highlight some of the concerns raised at the seminar about the study.

Link to my oral testimony:
http://www.galen.org/news/022802.html.
Full text of testimony:
http://www.galen.org/news/022702.html.

Grace Marie-Turner

RECENT PUBLICATIONS

Six Questions Everyone Should Ask about Health System Reform: an Application of Basic Economics

Jesse Hixson
Galen Institute

AMA Principal Economist Jesse Hixson offers basic but profound guidelines for achieving effective health system reform in his newest paper, "Six Questions Everyone Should Ask about Health System Reform: An Application of Basic Economics" (Galen Institute, 2002). The essay outlines key questions to guide policymakers in making decisions about reform initiatives:

- How does the proposed system confront scarcity?
- Is the system an equilibrium or disequilibrium system?
- What is the role of prices in the system?
- Are incentives facing producers and consumers consistent with reform goals?
- Who determines what health care is produced and who gets it?
- How will they know if it is working?

In addressing the questions, Hixson explores fundamental and undeniable economic principles that can serve as a guide to create a better and more efficient health care system. Policy makers can choose to ignore the economic truths outlined in the paper, but if they do, distortions, inefficiencies, and high costs will continue to afflict the system.

We have many copies of this nicely printed study, which should be useful for health policy and economics classes, conferences, and seminars. Please contact us for copies.

Full text of study (a pdf file): http://www.galen.org/news/Hixson_insidetext.pdf

Insurers Boost Individual Coverage Plans

Andrea Tortora
Cincinnati Business Courier

Proving that the individual health insurance market is growing, the *Cincinnati Business Courier* says insurance companies are increasing their individual plan options. A big new market is employees of small businesses: Hit with big cost increases, many are switching from small group plans to assisting employees in getting individual coverage.

John Clark of Cornerstone, which sells Medical Mutual's SuperMed Plus, says, "Sales are up 400 percent on individual plans. Some employers are endorsing individual plans or increasing salaries to help employees buy their own." Companies such as Humana are creating their own individual insurance products along with Anthem Blue Cross and Blue Shield of Ohio.

According to Deborah Moessner at Anthem, sales on individual plans increased 44 percent between 2000 and 2001 and 42 percent the previous year.

Full text of article (free, but requires sign-up):
http://cincinnati.bizjournals.com/cincinnati/stories/2002/02/25/story3.html

Canadian Provinces Move Toward Privatizing Healthcare

Barry Brown
The Christian Science Monitor

The premiers of Alberta, Ontario, and British Columbia say ballooning costs and long delays for some procedures can be solved only by private initiatives. "Our healthcare system is on life support, and it is fading fast," said British Columbia Premier Gordon Campbell.

Canada's universal health care system now eats up as much as 40 percent of provincial budgets. Originally a 50/50 split in financial responsibility between the national and provincial government, the national share has been declining for years, currently around 15 percent.

Provincial premiers, such as Ralph Klein of Alberta, have begun discussing for-profit health care and privatized contracting as alternatives. Klein is exploring the possibility of allowing more private hospitals, eliminating unionized employees, and offering profit-based incentives as a way to improve health care.

Full text of article: http://www.csmonitor.com/2002/0228/p07s02-woam.htm

Medicare: Communications with Physicians Can Be Improved

General Accounting Office, 02/2002

The House Budget Committee released a GAO study showing that when physicians call Medicare carriers for guidance on billing, they get information that is "often difficult to use, out of date, inaccurate, and incomplete." Bulletins are "poorly organized and contain dense legal language," and 85 percent of the answers provided through the toll-free line in a sample were "inaccurate or incomplete." The Web sites are no better: helpful only 20 percent of the time.

Further, doctors "reported being inundated with large volumes of complicated, unclear, and inconsistent information" that could lead to inadvertent billing errors. This is no small matter since doctors can be fined $10,000 for each billing error.

"It is becoming increasingly difficult for doctors to participate in the Medicare program," said Budget chairman Jim Nussle. "It is further proof that the Medicare program is too big and too burdensome and is in serious need of fundamental reform."

Summary of study (with link to full text):
http://www.budget.house.gov/022802a.htm

Material for this report is provided by The Galen Institute, P.O. Box 19080, Alexandria, VA 22320, http://www.galen.org. Grace-Marie Turner is president. This report is produced by Elizabeth Lamirand, who can be reached at 703/299-9550, and edited by Conrad F. Meier, managing editor of Health Care News.

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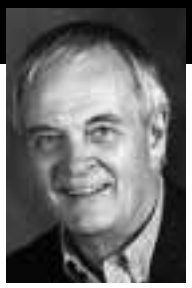

MY TURN BY CONRAD F. MEIER - MANAGING EDITOR

Free Market Meets Society's Needs

Anti-business activists are using the Enron debacle as an excuse to lay the blame for all manner of societal ills at the front door of big business, while calling for more government regulations.

Seems to me government itself is big business, and the amount of fraud going on in Medicare is no less shocking than what happened at Enron. If Medicare were selling on the New York Stock Exchange when billions of dollars in Medicare fraud was exposed, the stock would be worthless today, and thousands of bureaucrats would be out of their jobs.

Enron's failure should not be an indictment of big business any more than Medicare should be an indictment of all government agencies.

That said, big business, better than big government, has the opportunity to meet needs that no other giant organized entity—particularly one that is taxpayer-funded—can address.

Help for Needy Seniors

In January, another big business—one the media loves to hate, and one frequently maligned by the anti-business crowd—did something so fast and with so little fanfare as to make Congress look like a lumbering political blob.

Pfizer Pharmaceuticals, Inc., unveiled a prescription discount drug card that allows low-income seniors to buy all prescriptions filled by a Pfizer medicine for $15 for a 30-day supply. Celebrex, because it is co-marketed with Pharmacia Corp., is the only exception. The Pfizer plan went into effect March 1.

The plan's eligibility requirements are so simple they must be terribly confusing to the experts at Health and Human Services: You must be on Medicare; your income must be below $18,000 a year if you are single or $24,000 for couples; and you must not have any prescription drug insurance. You apply on a simple form; there is no membership fee and no monthly fee; you pay only for the prescriptions you use. You can fill your prescriptions at any pharmacy you choose.

Some seven million of the 40 million Medicare patients will be eligible, with no strings attached to Washington, no Congressional delays due to posturing, no taxpayer assistance, and no chance for obstruction by the likes of Tom Daschle or Ted Kennedy.

Flashback

Last November, I described in this column how some relatively little-known free-market programs, offered by virtually all pharmaceutical manufacturers, have been making medications more affordable for many years.

> **"The Pfizer plan is a free-market example of something government cannot do: It excludes those who do not need help and targets those who need the help the most."**

More than 60 drug manufacturers have "patient assistance programs" that make prescription medications more affordable for Medicare recipients, especially those with low incomes.

Pfizer, I wrote then, provided free—not discounted, but free—drugs for 600,000 people last year. Under those assistance plans, drug companies provide free medicines for those who have no prescription drug coverage and whose incomes fall below certain levels, regardless of age.

Fast Forward

Today, the best the government can come with is two plans, one by Republicans and the other by Democrats. Both involve so many rules, regulations, and deductibles that even the legislative aides writing the regulations are getting confused.

The federal government's prescription drug proposals suffer from a malady that afflicts most government programs: casting too wide a net. Governments do not target their social engineering efforts very well. Often, when the government attempts to help one group of people, other groups—less in need of help and perhaps even less desirous of help—nevertheless get it.

Pfizer, unlike Congress, recognizes precisely who needs prescription assistance. About 65 percent of people over age 65 already have some kind of financial coverage for prescription drugs. The remaining 35 percent have no insurance coverage for prescriptions ... but that does not mean they can't *afford* insurance, or their prescriptions. Some of these individuals voluntarily choose not to buy insurance.

After eliminating those who have prescription drug insurance, can afford to self-insure, or simply choose not to buy insurance, you get to the problem group: poor, mostly elderly, and mostly women.

The Pfizer plan is a free-market example of something government cannot do: It excludes those who do not need help and targets those who need help the most. It requires no new or expanded bureaucracy. Like all great ideas that work, it is uncomplicated.

Motivation

Some nay-sayers will question Pfizer's motivation. Let them. Pfizer's plan is a socially responsible response to a defined social problem. There is no shame in the fact the program may eventually increase Pfizer's share of the prescription market.

For more information...

WWW on free-market prescription assistance programs, see the Web site of the Pharmaceutical Research and Manufacturers of America (PhRMA). The group's 2001-2002 directory of assistance programs is available free of charge at **http://www.phrma.org/searchcures/dpdpap**.

Pfizer's move is good for consumers ... even for those who do not rely on Pfizer medications. Other pharmaceutical manufacturers are likely to follow suit, or they will lose their share of the market. Consumers will benefit from the competition and resultant lower prescription cost. In other words, it is good business all the way around.

While Enron may epitomize what is rare and ugly in the free market, we can look to Pfizer and others and see what is frequent and right in the world of big business. Our free markets, and the millions of citizens who work in them, have made America the envy of the world. No one needs to apologize for that.

YOUR TURN BY MILTON KAMSLER, M.D.

Individual Responsibility Is Key to Health Care Concerns

As I read *Health Care News* and appreciate your excellent coverage of health care issues, it upsets me to see the conservative health care reformers falling into the health care entitlement trap—effectively assuring only government entitlements can solve all the problems while downplaying individual responsibility.

Individual responsibility has been the mortar holding our country together and providing for the progress making us a great nation. From what I have seen and experienced over many years as a physician, individual responsibility is the essential ingredient government health care reform plans circumvent.

Top quality, affordable health care is dependent on the individual responsibility of each of the three main players in health care: the patients, the health care providers, and the third party providing payment.

They should be independent of each other except in those instances when the patient has no third-party payer. However, even when a competent adult patient receives financial assistance from a third party, the responsibility for obtaining, decision making, and following through with the management of health care and its payment should remain with the patient.

Physician peer review and government judicial oversight must be in place to help and protect the patient. Individual responsibility for decision-making and treatment as well as payment for services rendered must remain in the hands of each adult patient for the best possible outcomes.

This requires the necessary prioritization of the patient's wants and financial resources.

The attending physician as well as other providers must be held responsible for the health care management advised and provided. The third party must be held responsible for fulfilling the contractual agreement. However, the ultimate medical outcome is dependent on so many factors that it cannot be guaranteed.

Fortunately, most physicians and other health care support professionals are highly trained and compassionate in their desire to provide the highest standard of quality care for the advantaged as well as the disadvantaged.

Milton A. Kamsler Jr., M.D. is a retired physician living in Wisconsin. He can be reached at milt@kamsler.com.

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At what level of government:
_____ Federal
_____ State
_____ County or local

___ REFORM ACTIVISTS
Which best describes your role in the health care reform movement?
_____ Doctors' rights advocate
_____ Patients' rights advocate
_____ Taxpayers' rights advocate
_____ Employers' rights advocate
_____ Other: Specify _____

___ MEDIA
_____ Health care reporter/writer
_____ Print
_____ Electronic
_____ Other
_____ Print
_____ Electronic

___ BUSINESS
_____ For-profit company
_____ Non-profit company
_____ Trade association
_____ Chamber of commerce or similar organization

Return by Mail to: The Heartland Institute, 19 S. LaSalle Suite 903, Chicago, IL 60603 or fax this entire form to 312.377.5000

The information you have provided will be kept strictly confidential. The Heartland Institute from time to time offers its mailing list to organizations whose goals are similar to ours. If you prefer not to be contacted by such groups, please check here._____

Signature Required Below

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NMHCC

Uniting Healthcare Leaders

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KEYNOTE HIGHLIGHTS

The Regulatory Review: The State of the Healthcare System Address

Congressman Pete Stark
D-California, 13th District,
Ranking Minority Member,
Health Subcommittee,
Ways and Means

Congressman Tom Allen
D-Maine, 1st District,
Co-Chairman, House
Prescription Drug
Task Force

Honorable Kit Bond
R-Missouri

Alain Enthoven, PhD
Professor, Stanford
University (moderator)

Medicare Reform: Viable Options and Potential Outcomes

Gail R. Wilensky, PhD
John M. Olin Senior Fellow,
Project HOPE; Co-Chair,
Presidential Task Force to
Improve Health Care
Delivery for Our Nation's
Veterans

Who Will Pay for Healthcare in America: The Implications of New Health Delivery Models

Mark B. McClellan,
MD, PhD
Member, Council of
Economic Advisers,
The White House

The Bio Ethics Debate: Cloning, Stem Cells and the Future of Medicine

Francis Fukuyama, PhD
President's Council on
Bioethics, Bernard Schwartz
Professor of International
Political Economy; The Paul H.
Nitze School of Advanced
International Studies, Johns
Hopkins University

For full keynote roster see www.nmhcc.org/nmhcc

Special session topics dedicated to Healthcare Professionals include:

- *Report Card on Managed Care Successes and Failures: What Will It Take to Balance Quality and Costs?*
- *From Episodic Encounter to Longitudinal Care Management: New Research on Nurse Triage as an Early Identification Tool for High Risk Members*
- *Case Study HMO Partnership with Primary Physician Groups: Aligning Incentives*
- *The Next Frontier: Consumer-Driven Health Plans*
- *CASE STUDY: Humana's All Digital Health Plan*
- *Complying with HIPAA Without Breaking the Bank—or Your Back*
- *Wellness and Prevention Programs: The Next Generation*
- *The Changing Marketplace of Aging: A Blessing in Disguise for Healthcare Providers*
- *Technology Innovation in Real-Time: Safely and Efficiently Advancing What Works for Preparedness, Prevention and Treatment*
- *Who Will Pay for Healthcare in America: The Implications of New Health Delivery Models*
- *Is Managed Health Care Working? — Views on the US Health Care System*
- *Closing the "Health Status Divide": Reducing Cultural and Racial Disparities*
- *Managed Care University*
- *A Step-by-Step Guide to Cultural Competency in Managed Care Organizations: The What, Why & How of a Successful Cultural Competency Initiative*

EXHIBIT HALL HOURS

Monday, April 15, 2002

Dedicated Exhibit Hall Event
5:30 pm – 7:30 pm Grand Opening Reception

Tuesday, April 16, 2002
9:30 am – 2:00 pm Exhibit Hall Open
4:30 pm – 6:00 pm Exhibit Hall Open

Dedicated Exhibit Hall Events
9:30 am – 10:30 am Coffee break
12:45 pm – 2:00 pm Lunch
4:30 pm – 6:00 pm Networking Reception

Wednesday, April 17, 2002
9:30 am – 1:30 pm Exhibit Hall Open

Dedicated Exhibit Hall Events
9:30 am – 10:15 am Coffee break
12:30 pm – 1:30 pm Lunch

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